New Hampshire
Division for Children, Youth & Families
Practice Model
Safety ♥ Permanency ♥ Well-Being

NEW HAMPSHIRE

Division for Children, Youth and Families

*D*epartment of Health and Human Services

NEW HAMPSHIRE PROGRAM IMPROVEMENT PLAN

IN RESPONSE TO THE 2018 CHILD AND FAMILY SERVICES REVIEW






Submitted to:
U.S. Department of Health and Human Services
Administration for Children and Families

November 1, 2019 Third Submission

Submitted by New Hampshire Department of Health and Human Services
Division for Children, Youth and Families
129 Pleasant Street
Concord, NH 03301

NEW HAMPSHIRE CHILD AND FAMILY SERVICES REVIEW (ROUND 3)

PROGRAM IMPROVEMENT PLAN

State/Territory:	**New Hampshire**
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Jeffrey A. Meyers
Commissioner

Joseph E. Ribsam, Jr.
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF HUMAN SERVICES
DIVISION FOR CHILDREN, YOUTH & FAMILIES

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November 1, 2019

Mark Dalton, Children and Families Program Specialist
Administration for Children and Families
US Department of Health and Human Services (HHS)
John F Kennedy Federal Building
Room 2000
Boston, MA 02203

Re: New Hampshire Program Improvement Plan (Third Submission)

Dear Mr. Dalton,

In April 2018, the Children's Bureau completed a Child and Family Services Review of the New Hampshire child welfare system. The Child and Family Services Review report was reviewed by the New Hampshire Division for Children, Youth and Families to develop a Program Improvement Plan which addresses all of the outcomes and systemic factors which were determined to be not in substantial conformity. The Division is grateful for your feedback and support in the development of this plan over the past few months which will fuel a more cohesive progression going forward.

Since the first submission of NH's Program Improvement Plan, additional data analysis has been completed to more comprehensively understand the underlying causes leading to NH's area's needing improvement. Additionally, there has been more enhanced collaboration among stakeholders, staff, providers, and agency leadership when developing strategies, key actions and identifying implementation steps. We anticipate that the attached Program Improvement Plan will speak to the work of our two agencies collaboration in building a stronger child welfare program.

Sincerely,

Joseph Ribsam, Jr., Director
NH Division for Children, Youth and Families

Enclosures

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Executive Summary

The Child and Family Services Review (CFSR) conducted in April 2018, evaluating families served by DCYF during the *period under review*, April 2017-April 2018; found New Hampshire to be out of substantial conformity with all seven outcomes and five of the seven systemic factors. In response to the federal review, New Hampshire will develop and implement a Program Improvement Plan (PIP) for child protective and juvenile justice services that addresses all areas rated as not in substantial conformity.

Program Improvement Themes

To address the outcomes and systemic factors not in substantial conformity, one strong cross cutting theme emerged which has greatly affected all areas, workforce development and staff retention.

It is evident that having a robust and sustainable workforce, with supervisor and staff that have undergone initial and ongoing training specific to the demands of their job and who feel supported in their work is critical to the success of New Hampshire's families. Parents have reported feeling more confidence in their work with their caseworker when their caseworkers are knowledgeable about the kinds of supports and services that will help them with their specific challenges. Workforce and professional development is a theme, interwoven throughout all goals within the program improvement plan.

Six high level themes emerged across the results of the Child and Family Services Review, and within the goals of the Program Improvement Plan.

SAFETY, PERMANENCY, AND WELL-BEING OUTCOMES

- Timely responses to reports of child maltreatment
- Initial and ongoing risk and safety management
- Timely achievement of permanency
- Engagement of all children and all parents, particularly fathers

SYSTEMIC FACTORS

- Initial supervisory training and ongoing staff training
- Significantly diminished service array, including access to safety services, voluntary services, and the foster care system.

Organizing the Program Improvement Plan

More than 150 stakeholders participated in exploring the root causes of preliminary problem statements derived from data exploration. Nineteen focus groups were held with a variety of both internal and external

stakeholders. including: judges, attorneys, CASA/GALs, birth parents, youth in care, relatives and foster care providers, providers, contractors, and staff at all levels of the Division. Eight initial strategy development workgroups were established and included approximately 100 stakeholders. Over time, workgroup membership shifted allowing for additional participant involvement. These workgroups reviewed and explored data, developed and revised Strategies and Key Actions, and outlined implementation processes. New Hampshire closely collaborated with the Court Improvement Project to design improvement items for the permanency outcomes. Additionally, New Hampshire accessed support of the Capacity Building Center for States and Center for Courts with the development of theory of change, data analysis and root causes, and drawing connections with the data and development of strategies. Data exploration and root cause analysis is further explored within each goal area for each of these themes.

New Hampshire's case review process, conducted three times annually, will monitor progress toward the Program Improvement Plan. Results of the case reviews will be reported semi-annually utilizing a rolling periods to provide the most current information available. New Hampshire's case review tool, which mirrors the On-Site Review Instrument (OSRI), along with the Statewide Automated Child Welfare Information System/Comprehensive Child Welfare Information System (SACWIS/CCWIS) will be used to generate case review data. Please refer to New Hampshire's Measurement Plan for more details.

The Division and External Influences on the Program Improvement Plan

There have been several major factors beginning in 2011 and 2012, which set the course for New Hampshire's limitations in effectively meeting the needs of children youth and families including significant budget cuts preventing the Division from serving families through prevention, voluntary services and through children in need of services (CHINS) cases. In subsequent years, there were even more reductions, even when the needs of families changed.

In recent years there have been additional factors that influenced the development of New Hampshire's PIP:

- Increases in workloads combined with staff retention challenges that strained the child welfare system beyond capacity;
- A significantly diminished service array;
- The Child Welfare System Transformation was initiated in response to a third party quality assurance review of the New Hampshire Division for Children, Youth and Families; and
- Changes to state laws and the development of high level oversight by the Office of Child Advocate, impacting the Division for Children, Youth and Families

Over the past few years, the Division has experienced an increase in accepted reports of child abuse and neglect to investigate and a rise in the number of children entering out-of-home placement, straining both the State's personnel resources and the system's capacity to meet the needs of the State's population.

Child Protection struggled with an insufficient number of field workers and an increased workload. These significant increases occurred while staff were already struggling to meet individual case responsibilities.

There has been a wide variation in staffing across offices and disciplines over the last few years, with several offices operating with less than sixty percent staff capacity at various times. There is now a statewide understanding of the workforce issues that has challenged the Division and the dire need for DCYF to increase staff capacity to ensure best practice, and meet the service needs of the children, youth, and families it serves. Child protective staff have increased by sixty-five field positions since 2016. Although a step in the right direction, additional positions are still needed in order to reach reasonable workload standards. Further, multiple supervisors and support staff positions are also needed.

In 2014 and 2015, the Division experienced increasing external challenges that sparked major changes to the child welfare system. Revisions to statutory language and the development of various legislative commissions began to drive practice to identify gaps and recommendations to improve practices. The creation of the *Commission on Child Abuse Fatalities* resulted in the statutory requirement[1] of an Office of the Child Advocate (established in 2018) to work with the Division[2]. In response to public outcry, the Division embarked on critical system changes including the implementation of:

- Twenty-four hour, seven days per week coverage for the receipt of reports of maltreatments (February 2017); and
- After-hours response to imminent danger situations involving a child. (February 2017)

Also at this time an independent comprehensive review of the Child Protective Services of the Division for Children Youth and Families (DCYF) was conducted. The contract for this independent review was awarded to the Center for the Support of Families[3]. The review was initiated in May 2016 and was

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[1] In 2017, the New Hampshire legislature enacted RSA 170–G:18, which established the Office of the Child advocate to oversee the state's child welfare, child protective and juvenile justice services and to assure that the best interests of children are protected.

[2] The Office of the Child Advocate was established in 2018 as part of an aggressive commitment to reform New Hampshire's child welfare system. "We are an independent and impartial state office established to oversee the Division for Children, Youth and Families (DCYF). There are times when DCYF is involved in the lives of children and families. It is the Child Advocate's responsibility to make sure that the State of New Hampshire does the best job possible in caring for and protecting children."

[3] Center for the Support of Families https://sligov.com/solutions/center-for-the-support-of-families-csf/

released to the public on December 19, 2016. The report identified twenty recommendations to improve DCYF practice specifically in the area of assessing child abuse and neglect reports. A major issue identified was a "seriously overloaded [child protective] assessment workforce"[4]. The findings of this review led to the development and implementation of the New Hampshire Child Welfare Systems Transformation (CWST). Further quality assurance activities, including an Adequacy and Enhancement Assessment of the New Hampshire service array completed in 2018 by the Public Consulting Group, are adding to the Child Welfare System Transformation efforts to make a planned and comprehensive change to the overarching system in New Hampshire.

An integral part of the Child Welfare System Transformation effort is an Interagency Team (IAT), consisting of over thirty-five essential stakeholders with statewide representation which also includes birth parents, foster care providers and former youth in care, which has generated close collaboration with community stakeholders and the legislature. Interagency Team members have participated on workgroups that have tackled every one of the recommendations of the independent review to partner with DCYF in the transformation of the child welfare system in New Hampshire.

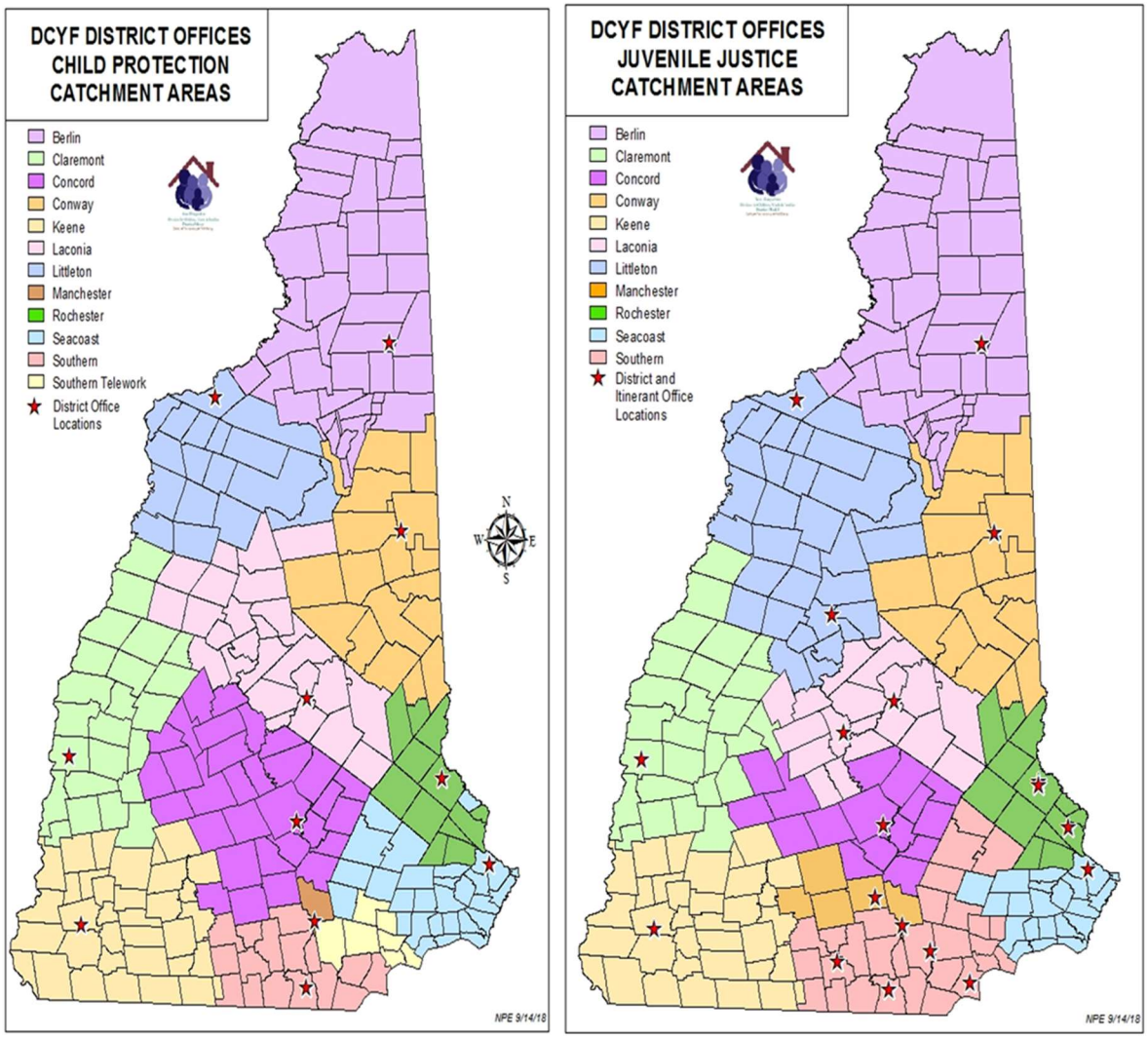
DCYF and stakeholders have put the recommendations of the independent review in the forefront and recognize that the need for changes to go beyond just DCYF reform to a true systems transformation. With the addition of data from the Child and Family Services Review (2018), the Adequacy and Enhancement Assessment (2018), the Program Improvement Plan, and the Child and Family Services Plan, DCYF has begun strategic planning to effectively manage the transformation work that DCYF will continue to embark upon over the coming years.

Division goals will be achieved through building workforce capacity, increased cross-systems collaboration within the Department of Health and Human Services, with other state agencies, community organizations, and judicial stakeholders, including investment in the enhancement of service array and continuum of care for New Hampshire families. DCYF leadership, field staff, and stakeholders believe New Hampshire is well positioned to work together to construct a safer future for all New Hampshire's children.

[4] *https://www.dhhs.nh.gov/dcyf/documents/csf-qa-review-report.pdf*

New Hampshire's legislature has heard the strong advocacy in support of the need for more staff, more resources and money to expand the State's service array and is responding in support of these needs. The Division is confident that resources will be fully levereged to achieve the goals of this program implamenation plan.

Child Protection and Juvenile Justice Catchment Areas



New Hampshire operates a state administered program comprised of eleven district offices, and five additional juvenile justice itinerant offices.

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Part One: Goals, Strategies, and Key Activities

Goal #1: (Safety)

CFSR OUTCOMES: SAFETY 1, 2

Improve the timeliness, quality, and statewide consistent utilization of child and family safety and risk assessments throughout the life of the assessment or case.

For cases reviewed during the *period under review*, [April 2017 to April 2018], New Hampshire was not in substantial conformity with Safety Outcome 1 and received a rating of *area needing improvement*, as fifty-two percent of the twenty-nine applicable cases reviewed received a strength rating. Although timeliness of assessments (Item 1) ratings for juvenile justice cases scored lower than in child protective cases, it is typically identified as the responsibility of child protection to commence assessments and interview victims. This indicates a need to improve collaboration between child protective and juvenile justice workers. The documentation shows that in-home cases rated worse than placement cases for Item 1; however, as both ratings are low, the strategies for this Program Improvement Plan will focus on both in-home cases, including assessments, and placement cases.

For cases reviewed during the *period under review*, [April 2017 to April 2018,] New Hampshire was not in substantial conformity with Safety Outcome 2. The outcome was substantially achieved in sixty-five percent of foster care cases and sixteen percent of in-home cases (including assessments). This indicates a need to make improvements in both case types; however, this Program Improvement Plan will prioritize in-home cases (including assessments).

A rating of *area needing improvement* was received for *Item 2: Services To Protect Child(Ren) In-Home And Prevent Removal Or Re-Entry Into Foster Care* as only forty-one percent (41%) of the applicable cases reviewed received a strength rating. Of the small number of applicable cases for this Item, forty-seven percent (47%) of the child protective cases rated as strengths and these were all assessments. Of the two applicable juvenile justice in-home cases, zero percent rated as strengths. Although the Division needs to ensure safety related services for all families, this Program Improvement Plan will prioritize in-home cases for both juvenile justice and child protective services, specifically for child protective assessments.

All cases were applicable for *Item 3: Risk And Safety Assessment And Management*, with only forty-eight percent (48%) of cases reviewed, receiving a strength rating. Child protection cases scored slightly higher at a fifty-two percent (52%) strength rating compared to juvenile justice cases, which rated at thirty-eight percent (38%) strengths. Of specific concern were in-home cases, including assessments, of which all nine rated as an *area needing improvement*. In evaluating performance across district offices reviewed during the CFSR, all required significant improvement on Safety Outcome 2. While still an *area needing*

improvement, the Seacoast District Office rated the strongest in safety assessment and management at above forty-eight percent (48%), and rating zero percent on safety planning. Both Manchester and Conway rating below thirty percent (30%) strengths on Item 3.

ROOT CAUSE PROCESS

New Hampshire researched and analyzed qualitative and quantitative data to determine the root cause of the Division's struggle to meet initial face-to-face visits within timeframes on assessments; accurately assess for risk and danger; and provide appropriate services or safety plans to address safety. Data staff conducted analysis and a deep exploration into the quantitative results and the qualitative narratives for each Item of the On-Site Review Instrument to identify themes in practice that led to the *area needing improvement* ratings. From these themes, problem statements were developed. Subsequently focus groups were held with Assessment Child Protective Service Workers, Family Service Child Protective Service Workers, Juvenile Justice Policy group (officers, supervisors, and other DCYF staff), and DCYF attorneys to process "the Five Why's" of the following problem statements:

- *Safety Plans* are not consistently comprehensive to address safety concerns;
- There is limited monitoring of Safety Plans;
- The services referred do not adequately match the need to mitigate risk;
- All caregivers, especially fathers are not being assessed to ensure the safety of their children; and
- DCYF is not seeing and assessing all children in the home, only the petitioned child is prioritized ongoing.

Possible root causes identified through the focus groups were further evaluated. Data from the statewide automated child welfare information system (SACWIS) known as Bridges was queried to evaluate: overdue assessments, accepted assessments, and trends over the last four years on timeliness of initial face-to-face visits. Specific attention focused on differences between district offices based on many factors including, but not limited to: assessment volume; population demographics; social deterrents; and staffing. Further, data from *Youth Surveys* and *Random Moment Sampling* results were reviewed as well as research into staff trainings offered verses attended and DCYF policy.

The following root causes emerged as contributing factors for New Hampshire's low performance on the safety outcomes:

- Workforce capacity;
- Lack of sustained attention to practice standards;
- Lack of use of data to improve practice; and
- Lack of method to track deadlines.

These causes drove the creation of the strategies to improve performance in the following practice areas:

- Increasing timely face-to-face responses to reports of maltreatment;
- Reducing the current state of overdue assessments;
- Increasing use of data driven tools around risk and safety assessments; and
- Developing and monitoring the progress on, or amending safety actions to assure children are protected from harm.

TIMELY RESPONSE AND FACE-TO-FACE TIMEFRAMES DATA ANALYSIS

The Division's interpretation of policy and subsequent responses to reports of maltreatment was identified as an *area needing improvement* rating on Item 1. Division policy identifies that on *Level 1*, *2* and *3* assessments, face-to-face victim interviews need to occur within 24, 48 and 72 hours respectively.

The Division's interpretation and practice had excluded weekends and holidays when measuring these timeframes, with exception of reports received through the on call system, where it is determined by an On-call Supervisor that an in-person response is required to ensure safety, as the Division's normal business hours are Monday through Friday, excluding holidays. When weekends and holidays are not considered for meeting timeframes, the Division rates significantly better in timeliness of reports where victims were seen within the required timeframes. This makes sense, as the timeframes are less stringent.

DIVISION FOR CHILDREN, YOUTH AND FAMILIES TWENTY-FOUR/SEVEN IMPLEMENTATION

Background

RSA 169-C: 34, I, mandates that if it appears that the immediate safety or well-being of a child is endangered, the family may flee or the child disappear, or where other factors warrant, the Department must immediately commence an investigation. In all other cases, a Child Protective Investigation must be initiated within seventy-two hours of receipt of the report.

In 2016, in response to this legislative mandate and as an ongoing commitment to protecting New Hampshire's children, DCYF decided to expand its Child Protective Services operations to ensure twenty-four hour availability to the public, including: an After-Hours On-Call Response System, a Statewide Assessment Team, and an After-Hour Intake service that is operated by Wediko Children's Services.

The CFSR results indicated a high concern for timeliness of *Level 1* assessments due in part to the discrepancy between the written policy and interpretation of practice for meeting face-to-face timeframes. Notably, data shows *Level 1* timeframes are met more frequently than *Level 2* or *Level 3* timeframes. In order to understand better the differences across the state in adherence to timeframes data, face-to-face timeframes were evaluated across district offices.

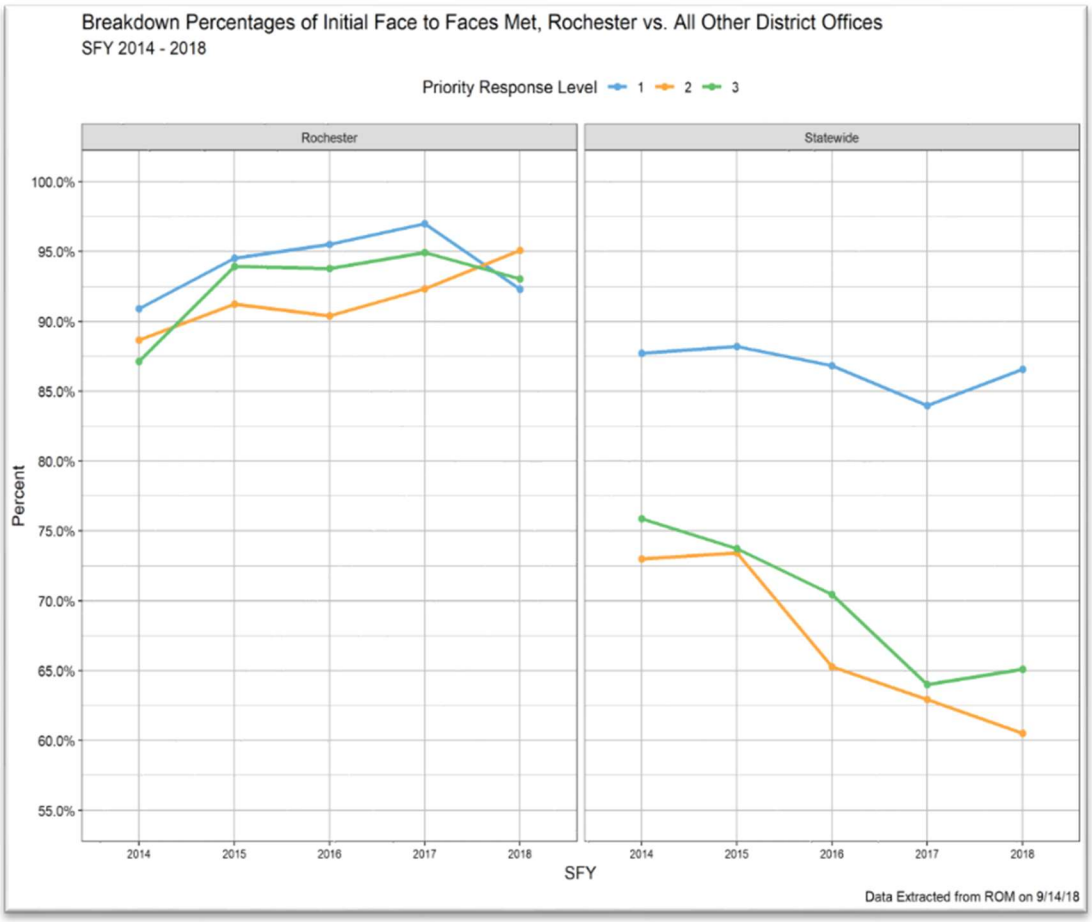


Figure 1.1: Rochester District Office shows the best overall performance in terms of consistency across Response Priority Levels while statewide trends show a significant decrease in the timeliness of contacts, specifically for level two and three assessments

Figure 1.1 illustrates trends in face-to-face timeframes for the highest rated office, Rochester District Office, compared to trends from other district offices in accordance with practice, across state fiscal years, and is broken down by the *Priority Response Level*; which are ordered from one through three by time allotted (least to most) to complete the timeframe. Meeting timeframes for *Level 1* assessments continued to occur at a significantly higher rate than *Level 2* and *Level 3* assessments. It can be surmised that these timeframes are met more consistently because *Level 1* timeframes require a 24-hour response and specific staff are identified in each district office to respond to these high priority assessments immediately. In most district offices, *Level 2* and *Level 3* assessments are not triaged in the same manner, in fact, root

cause analysis identified that different supervisors have different skill levels around managing and supporting assessment workers in this area.

By using an Appreciative Inquiry approach, the Division explored how offices that had higher ratings in meeting timeframes with victims were successful in managing this. The office with the most success in this area across all *Response Priority Levels* is the Rochester District Office. This office attributes its' success to the daily attention paid to supervising by data and engaging all staff in a teaming approach. Specifically, all assessment staff in Rochester meet each morning to discuss interview timeframes for all newly assigned assessments. As a team, the staff plan how to meet the timeframes and workers routinely support each other in ensuring face-to-face timeframes are met, regardless of whom they are assigned to. In review of Rochester's average workforce capacity, assessment staff were functioning at sixty-three percent capacity in calendar year 2018, yet were able to maintain their attention to meeting timeframes. Rochester was operating approximately 10% below the statewide workforce capacity for assessment staff, which was approximately 74%. Again, supervisors in the Rochester District Office attribute the adherence to timeframes on sustained attention to the efforts of the office to work together in order to ensure expectations are met.

Southern District Office staff follow a similar process and, although their results are not as strong as those of the Rochester Office, they do have success in this area. Therefore, based on lessons learned from these district offices around supervisory management and support, the Division will address supervisory capacity by creating practice guidance around supervising by data, a daily team review of assessment status, and increasing partnerships between staff. Other ways to increase supervisory capacity are included under the ***Workforce Capacity Goal, Strategies 1 and 2***.

Safety Strategy 1: (Outcome Item 1)

Supported by BOLQI and Field Administrators, Supervisors will begin implementation of a pro-active tracking system and a daily teaming "triage" process, which will include coaching of staff by supervisors in order to build staff skill in assessment practice, as well as improve decision making and compliance with meeting all face-to-face timeframes.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 8

THEORY OF CHANGE:

CFSR findings from the *period under review*, [April 2017- April 2018] resulted in fifty-two percent (52%) of applicable cases being rated as a strength for Item 1, *Timely Responses To Reports Of Child Maltreatment*. Data shows the level of consideration and priority given to the timeframes by supervisors and assessment workers impacts timely responses to reports of child maltreatment. The Rochester District Office has been utilizing a daily meeting since 2011, which includes review of data, tracking timeframes and implementation of a teaming approach. Even during times when the office Assessment Unit has been operating below capacity, Rochester sustained their attention to meeting timeframes with the same consistency. This is largely due to their daily meeting, which is CPSW facilitated, as well as the shift in office culture that every staff is responsible for all assessments/timeframes within the office. This teaming approach has extended to include support from juvenile justice staff when the assessments have families with whom they are involved. DCYF theorizes that if a similar data driven and teaming approach to planning assessment timeframes can be established within every district office, staff will learn how to utilize data to prioritize timeframes and decision making. Additionally, offices will develop a culture of teamwork, and these will result in an improvement in timely responses to all reports of child maltreatment at a rate as identified in the measurement plan. New Hampshire through the work in the *Child and Family Services Plan* will be moving toward a two-level system with a 24 hour response and a 72 hour response based on identified risk level at the time of screen in. There will need to be policy revision that takes into account weekends and holidays, elevates responses when appropriate if the timeframe falls on a weekend or holiday, outlines an after hours response to reports of maltreatment, as well as recommendations from DCYF's work to revise SDM tools.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. Revise Policy 1171, to reflect inclusion of weekends and holidays; 2. Revisit and revise Policy 1171 to reflect change in screen in leveling system.	Quarter 1 Quarter 2	

3.	Prepare, obtain approval, and distribute a practice change email to the field outlining strategic compliance expectations within the first 30 days: a) The critical importance of keeping kids safe; b) The CFSR findings and compliance timeframes; c) The need for proactive and sustained efforts to improve safety and outcomes through ensuring face-to-face timeframes are met; d) The roles and responsibility of field administrators and supervisors to these efforts, and, e) Clarifying the expectation for state wide implementation of a supervisor or other designee lead daily "triage" process utilizing a proactive tracking system to monitor, troubleshoot and assign referrals in a timely manner to ensure sustained compliance to all timeframes, and supervisors will utilize opportunity for co-occurring practice discussions to reinforce best practice and staff skill building.	Quarter 1	
4.	During the first quarter, the Bureau of Organizational Learning and Quality Improvement (BOLQI) and Field Administrators will begin working directly with district offices to develop a daily triage process utilizing a proactive tracking tool. a) The core components for each plan should include: I. Offices will review and create a plan to address a face-to-face response for new assignments, what is coming due and what is overdue on a daily basis II. Offices will continue to review daily until a face-to-face is met and documented, and if attempts have been unsuccessful, develop a new plan to address these face-to-faces responses. III. Offices will use a system to track these assignments (i.e. tracking tool, assigning sheet, print out of workload) which includes attempts and if the face-to-face is documented. b) Roll out to three to four district offices each month over a three to four month period based on criteria including: applying qualitative and quantitative data analysis and/or field administrator recommendation.	Quarter 2 Quarter 3	
5.	Following meeting with BOLQI and Field Administrative staff, district office staff will submit their office tracking plans to their Field Administrators and these will be reviewed with staff from BOLQI for final approval.	Quarter 2	

6.	Supported by BOLQI staff, Field Administrators will track compliance (ROM data) for all timeframes on a monthly basis ongoing, and if compliance is not improving, provide coaching/training and oversight to the field within first 90 days of implementation. a) Will work directly with those district offices supervisors to coach, train, troubleshoot and resolve issues to coming into compliance on face-to-face timeframes and; b) As needed, BOLQI staff and other bureaus will work directly with those Field Administrators of district offices that are not showing compliance improvement in meeting face-to-face timeframes.	Quarter 4 Quarter 5	
7.	BOLQI will establish a baseline "District Office Level Compliance Report" on compliance to Level 1, 2, and 3 face-to-face timeframes and work directly with Field Administrators to set three, six and nine month compliance improvement goals*	Quarter 1	
8.	BOLQI will run a trending report on a quarterly and ongoing basis in order to evaluate the effectiveness of this Strategy.	Quarter 3 through Quarter 8	
9.	Data and performance will be monitored during monthly leadership team meetings. During monthly leadership meetings with supervisors, Field Administrators and BOLQI will: a) Co-present the district office level compliance "trending data" (from the start of implementation to date) including each district office's three, six and nine month compliance improvement goals* and, b) Co-lead the discussion on: • The importance of prioritizing efforts to ensure safety for kids; • The need to come into compliance with meeting face-to-face timeframes practice; and • The sharing of successful lessons learned and the recognition of those offices seeing improvement; celebrate success and recognize supervisors and their workers.	Quarter 3- through Quarter 8	
10.	The Division anticipates seeing timely face-to-face timeframes improve as determined by the measurement plan for Item 1.	Quarter 8	

Overdue Assessment Data Analysis

The Division has historically experienced a significant number of overdue assessments that remain open for extended periods of time, creating bottlenecks in the system. DCYF policy allows for an assessment to be open for 60 days.

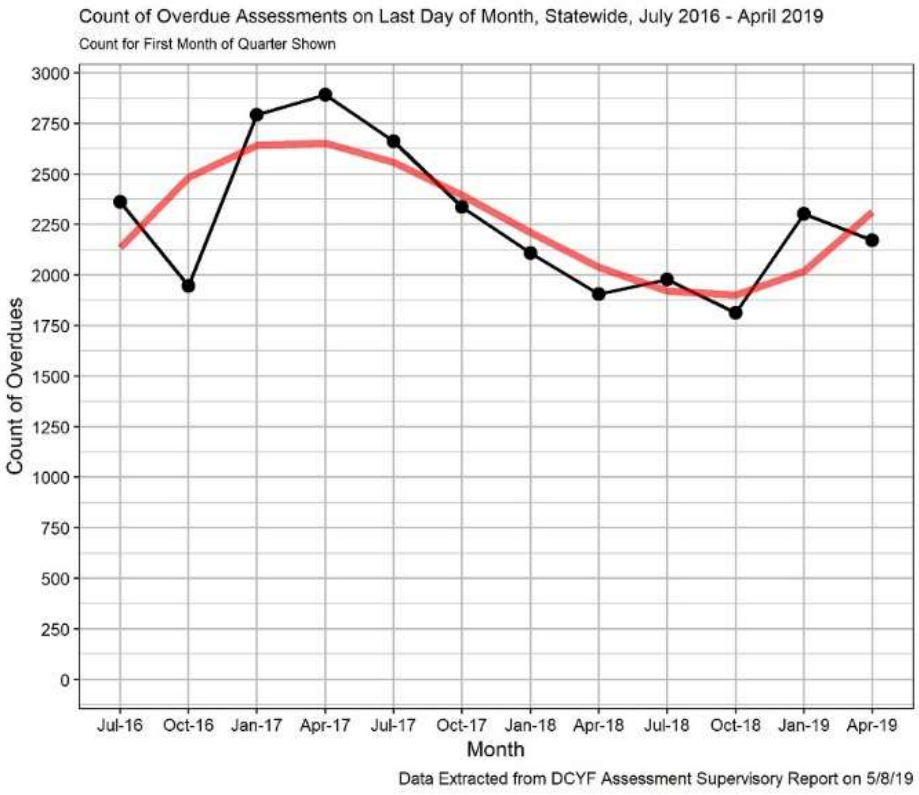


Figure 1.2 Count of overdue assessments on the last day of the month statewide.

Figure 1.2 tracks the number of assessments classified as overdue on the last day of the month from July 2016 through March 2019. Fifty percent of the months had over 2,350 overdue assessments. Downward trends began in June 2017 as a result of sustained attention to closing overdue assessments. In April 2017, staff were permitted to receive overtime pay to close overdue assessments. Over 3,500 assessments have been closed during overtime hours since the inception of overtime pay. In January 2018, DCYF contracted with an agency to provide assistance in completing closure tasks on overdue assessments and later contracted with three individual service providers to also assist in completing closure tasks. The contracted agency provided six part-time case support specialists, who made collateral calls with providers and specialists, gathered medical/educational records, completed risk assessments, wrote closing summaries, and closing letters based on the assessment contacts. These case support specialists have human services backgrounds and are qualitifed to complete these administrative tasks. The assessment was then sent back to the district office for closure with a DCYF Supervisor. The agency assisted with over 1,650 overdue assessments before the contract ended in December 2018. In January 2019, individual contractors assisted with an additional 365 overdue assessments. When contracted assistance is available these combined efforts have shown to be sufficient to safely reduce the number of overdue assessments based on volume. Figure 1.2 also illustrates that each month between October 2018 and February 2019, there was a record high volume of new assessments accepted, which again created an upward trend in overdue assessments, peaking in February.

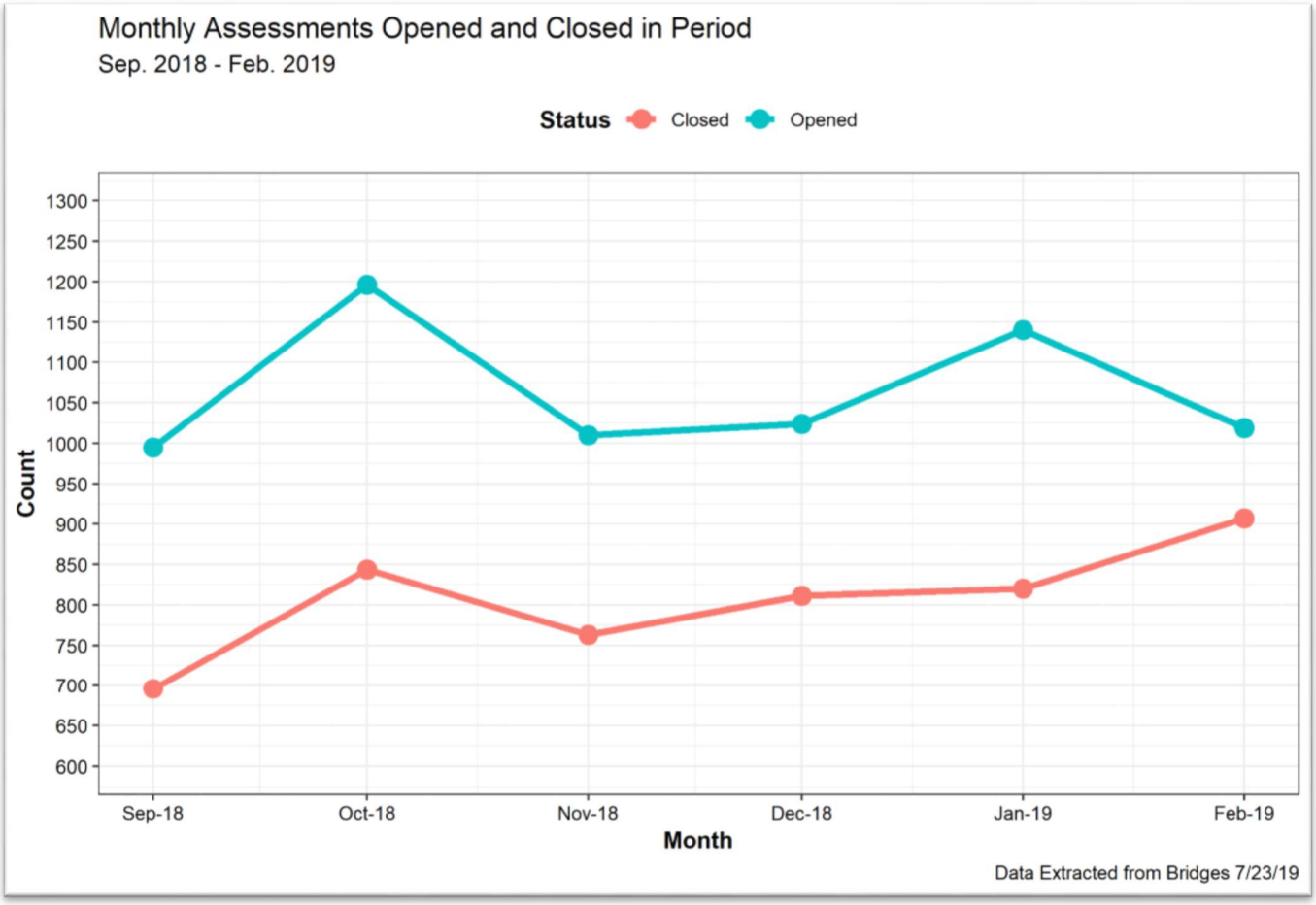
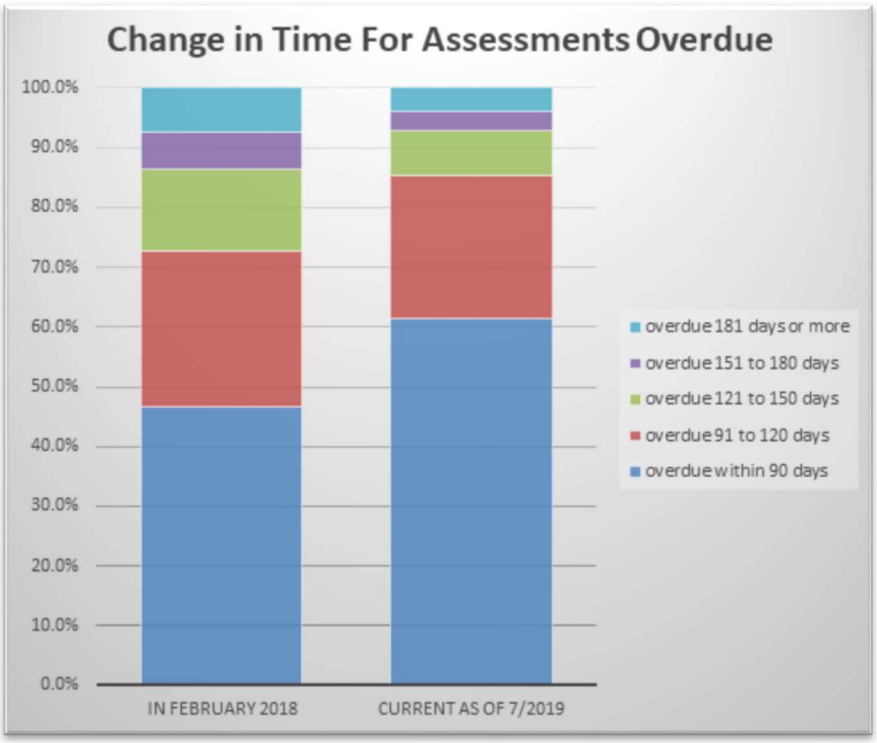


Figure 1.3: Comparison between the number of new assessments opened and number of assessments closed.

A perceived barrier contributing to overdue assessments is that the pace at which assessments are closing has tended to nearly match the rate at which new assessments are accepted. The ratio of assessments closed over the ones opened within the same month nearly follows a one-to-one relationship. Increasing this ratio will effectively reduce the backlog of overdue assessments, which maintains around 2,000 in any given month. Some ways to achieve this include: examining the Screen-In Criteria for reports of maltreatment, establishing a means to manage and close assessments based on their assigned risk level, and sustaining attention on closing assessments that have become or are about to become overdue.

A second perceived barrier and contributing factor to overdue assessments is the belief that the increase of new assessments prohibits staff from being able to complete an assessment. In an attempt to keep up with new timeframes, staff are prioritizing new assignments over closing tasks. While one cannot definitively state the increase in accepted referrals prohibits staff from being able to complete an assessment, when combined with workforce capacity issues it most certainly could negatively impact staff's ability to sustain attention on completing assessment closure tasks and closing assessments timely.



Data extracted from Bridges 7/25/19

Figure 1.4: The number of overdue assessments are overdue within 90 days.

There is no question that New Hampshire needs to manage assessments in such a manner that they do not become overdue and remain open for lengthy periods of time. Figure 1.4 illustrates a positive trend over the last year in the manner in which assessments are being managed. Assessments overdue 90 days or less increased by 15% over the prior year, due specifically to a reduction in the assessments open 121 days or more. There is a decrease in the length of time assessments are remaining open once they are overdue, which suggests that NH's practice is trending in the right direction.

Safety Strategy 2: (Outcome Item 2 and 3)

Reduce the number of current overdue assessments and decrease the volume of new/future overdue assessments in order to improve safety for children.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 8

THEORY OF CHANGE:

CFSR findings from the *period under review*, [April 2017- April 2018] for Item 2 *Services To Protect Children* was rated a strength in forty-one percent (41%) of applicable cases and Item 3 *Risk And Safety Assessment And Management* was rated a strength in forty-eight percent (48%) of applicable cases. Data shows in Figure 1.3 that there has been a steady increase in accepted referrals and the number of new assessments assigned outweighing the number of assessments being closed. Due to an increasing volume of new assignments, combined with workforce capacity needs, staff are struggling to balance working on new assessments with completing closing tasks for older/overdue assessments. Additional resources (such as overtime pay and the use of contractors to close assessments) have proven to yield a positive impact on the reduction of overdue assessments. Given the success of the contracted agency to help complete closing tasks on overdue assessments, four full time Case Support Specialists positions were created to work in the district offices completing the same tasks as the part-time positions from the agency had done. NH Sentate Bill 6, approved an additional 57 CPSW positions and 20 Supervisors over the next biennium (2020-2021). Having these positions in place will support NH's efforts not only in safely reducing the number of overdue assessments but should have a positive impact across the system. When new staff are able to manage a full workload, seasoned staffing levels will decrease, which will allow all staff to focus on closing timely and managing overdue assignments. This Strategy will focus on redefining screen-in criteria and exploring new ways to manage assessments based on risk levels as well as the continued use of additional resources to close the overdue assessments. This work will begin during the PIP period; the work will carry over into the Child and Family Services Plan. DCYF theorizes that these approaches to closing assessments in conjunction with efforts to improve workforce capacity will reduce the backlog of overdue assessments, create workloads that are more manageable, improve workers' ability to close assessments timely, and most importantly improve safety for children. Additionally, by increasing the number of assessments closed timely by 30%, this will reduce the backlog, by not contributing to it.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. Expand DCYF's workforce beginning Quarter 1. a) Identify targeted recruitment efforts for CPSWs	Quarter 1	

	b) Establish centralized interview process for CPSW positions c) Expand number of CPSWs and Supervisors based on allowances in legislation (27 CPSWs and 9 Supervisors during SFY20; and 30 CPSWs and 11 Supervisors during SFY 21). d) Utilize new staffing levels to manage assessment tasks including closing overdue assessments.	Quarter 1 Quarter 8 Quarter 2	
2.	DCYF will continue to utilize a variety of approaches to improve capacity to close overdue assessments, and address the backlog of assessments, including: a) Continues to expand number of case support specialists closing assessments in district offices, based on allowances in legislation b) Increase opportunities for training new case support specialists in associated tasks with conducting and closing an assessment (i.e. completing risk and safety assessments, identifying and interviewing appropriate collaterals, making facilitated referrals to community resources, etc.)	Ongoing/ Quarter 1- Quarter 8	
3.	Re-define Screen-In Criteria based on data to assure resources are utilized to assess families where child(ren)/youth are most likely to be unsafe and/or at risk of repeat maltreatment a) Utilize data to identify assessments most likely to be safe and low to moderate risk as identified through Structured Decision Making tools. b) Update abuse/neglect policy definitions to clarify what referrals are accepted based on risk level of repeat maltreatment and potential for unsafe outcomes. c) Work with the National Council on Crime and Delinquency to update Intake Screen-In Criteria. d) Incorporate updated SDM tools into the new CCWIS. e) Train staff on new policy. f) Work with NCCD to provide dedicated feedback and coaching for Intake workers (including the after-hours Intake contractor) to improve quality of screen-in decision-making and referrals.	Quarter 4 (overall) Quarter 1 Quarter 1 Quarter 1 Quarter 3 Quarter 3 Quarter 4	
4.	In an attempt to minimize the likelihood of a high volume of assessments that become overdue in the future, while still assuring the safety of children, DCYF will implement a revised assessment policy and practice that outlines differing expectations for managing and	Quarter 8 (overall)	

closing newly assigned assessments based on the family's assessed risk level. a) Define low, moderate, and high risk through updating Structured Decision Making (SDM) tools through work with the National Council on Crime and Delinquency. b) Through support with NCCD, and their national data driven research review and revise former alternative practice process to manage and close low and moderate risk level assessments. This will include identifying which tasks will be required based on assessed risk level in the SDM Risk Assessment. c) Update policy; d) Incorporate updated SDM tools into the new CCWIS; e) Train staff on new policy; and f) Supervisors and field administrators will utilize available tools and reports such as ROM, monthly data reports and dashboards to track improvement of practice, to evaluate the process success or need, monitor and improve trends, as well as determine outliers.	Quarter 5 Quarter 5 Quarter 5 Quarter 6 Quarter 6 Quarter 8	
5. The number of assessments closed timely according to policy (60 days) will increase to 30% by quarter eight (currently at 23%), which will reduce the number of assessments becoming overdue.	Quarter 8	

DATA DRIVEN TOOLS AROUND RISK AND SAFETY (RAPID SAFETY FEEDBACK) DATA ANALYSIS

Many child welfare agencies have begun to adopt the use of data to complement the tacit knowledge of their workforces with additional insights. Many jurisdictions have begun using data to help:

- Estimate elevated risk of maltreatment, serious injury, or child fatalities;
- Predict the likelihood of repeated maltreatment or re-entry into foster care; and
- Evaluate caseloads and worker turnover predictions.

In New Hampshire's case, the Division uses data to determine the highest five to seven percent of children/youth, who are referred to the agency, at an elevated risk of fatality or serious injury for children/youth known to the Division from a prior accepted report, regardless of finding, within twelve months of that previous accepted report. The data model is coupled with a quality assurance process to assure proper assessment milestones are met via coaching and support meetings with field workers involved on an assessment in a program called Rapid Safety Feedback (RSF). Based on the number of children identified eligible for Rapid Safety Feedback between January and June 2019, where there was full state participation in the program, it can be estimated the approximate number of children who may be served over the next year.

Low Estimate: 596 | Mid Estimate: 756 | High Estimate: 964

Although RSF has only begun to be implemented in May of 2018, with all district offices participating as of December 2018, the preliminary results are promising in terms of safety interventions, findings, and even the length of time an assessment remains open.

In Eckerd's quarterly review of Rapid Safety Feedback in June of 2018, they noted early strong "…responses from the tool are in the areas of safety interventions and referrals and recommendations. Some of the opportunities for practice improvement from the tool are in the quality and frequency of interviews with family members."

In terms of findings, RSF has shown promise in identifying youth with elevated risk. This can be seen by comparing the finding rates of assessments involved in RSF compared to all assessments during April 2018 through January 2019. Rapid Safety Feedback was involved with 102 assessments that closed and had a substantiation rate six percent higher than statewide (closed 6,052).

PROPORTION OF ASSESSMENTS CLOSED FOUNDED	
RSF ASSESSMENTS	**ALL ASSESSMENTS**
17%	11%

Figure 1.5

In terms of time an assessment remains open, assessments involved in RSF tend to remain open for shorter time periods. Figure 1.6 compares the median and average number of days for closed RSF assessments and all closed non-RSF assessments statewide during April 2018 through January 2019. There is a seventeen day difference between the median groups:

	RSF ASSESSMENTS	ALL ASSESSMENTS
MEDIAN DAYS REMAINED OPEN	**79 DAYS**	**96 DAYS**
AVERAGE DAYS REMAINED OPEN	**86 Days**	**147 Days**

Figure 1.6: Compares the median and average number of days for closed Rapid Safety Feedback assessments and non RSF assessments

Safety Strategy 3: (Outcome Item 2 and 3)

Reduce the probability of children and youth in child protective assessments and subsequent non-court involved cases experiencing death or serious injury by continuing to utilize and operationalize the Rapid Safety Feedback model to identify and monitor safety.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 8

THEORY OF CHANGE:

CFSR findings from the *period under review*, [April 2017- April 2018] for Item 2 *Services To Protect Children* was rated a strength in forty-one percent (41%) of applicable cases and Item 3 *Risk And Safety Assessment And Management* was rated a strength in forty-eight percent (48%) of applicable cases. CFSR findings indicated New Hampshire needs to better identify families who are at highest risk and respond with appropriate safety interventions or referrals to reduce and mitigate risk. A primary component of the Rapid Safety Feedback model is mentoring and coaching child welfare professionals during a teaming process in utilization of critical decision-making skills. The Rapid Safety Feedback model also empowers supervisors to model and reinforce ideas and skills with their staff, and to identify action items that can immediately influence the safety of the children involved. New Hampshire initiated Rapid Safety Feedback in May 2018 in three district offices, and completed roll out to all district offices in January 2019. Qualitatively, some staff who have been involved in a Rapid Safety Feedback assessment report having a better understanding of what to assess and how to comprehensively and purposefully document their assessment of safety for children and youth. DCYF theorizes that workers will become more skilled through the Rapid Safety Feedback coaching process and as a result will assess and manage risk and safety more thoroughly. Through interactions with families, workers will show quality assessment of safety, risk, future danger, and child vulnerability factors, and parental protective capacities, and develop appropriate safety interventions, and/or referrals to meet the family's needs.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. Rapid Safety Feedback staff will continue to review RSF referrals, coach workers and their supervisors to develop critical action steps, and monitor the completion of critical action steps and *Safety Plans*.	Ongoing/ Quarter 8	
2. Continue to use coaching by Rapid Safety Feedback staff to model for supervisors and staff expectations around assessment of safety and safety planning and build capacity of staff to conduct more thorough assessments.	Ongoing/ Quarter 8	

3. Rapid Safety Feedback staff will continue to coach and model for supervisors how to set expectations with their staff around assessment of safety and safety planning.	Ongoing/ Quarter 8	
4. Begin to utilize Assessment Practice Review data and Eckerd Fidelity Reviews to inform and evaluate improvements across practice.	Ongoing/ Quarter 8	
5. Sustain, evaluate and refine RSF based on demonstrated progress and improvements.	Ongoing/ Quarter 8	
6. Incorporate refinements of RSF into core academy training for staff and supervisors.	Ongoing/ Quarter 8	

SAFETY PLANS AND SUFFICIENT MONITORING OF SAFETY PLANS DATA ANALYSIS

In review of Item 3 of the On-Site Review Instrument for the 2016 and 2017 Case Practice Reviews, there were twenty-six cases, both in-home and placement, that rated as an *area needing improvement*. Notably, there were three questions in which over fifty percent of the cases rated as area needing improvement rated poorly. These included ongoing assessments that accurately assessed all of the risk and safety concerns for the target child in foster care and/or child in the family remaining in the home; when safety concerns were present developing an appropriate *Safety Plan* with the family and continually monitoring; and lastly, if safety concerns were adequately or appropriately addressed by the Division. The case sample was representative of both child protection and juvenile justice. Of the juvenile justice cases with an *area needing improvement* rating, 67% (four out of six) did not develop an appropriate *Safety Plan* nor continually monitor the *Safety Plan*, compared to fifty percent of the child protective cases rated as an area needing improvement on Item 3. Based on a qualitative evaluation of the results of the 2018 Child and Family Services Review, parental substance use and domestic violence were the most common areas where safety plans were either inadequate and/or safety related services were needed but not provided. safety related services will be addressed under *Goal 5: Service Array Strategy 3.*

It was identified during root cause analysis that in juvenile justice cases the entire household is not consistently included when assessing the risk and safety, most typically, the target child (or petitioned youth) is included. There were a number of barriers for this lack of engagement, further explained and addressed in *Goal 3: Engagement Strategy 1.* Likewise, in family service cases there is not always an identified focus on ensuring that all youth and parents in the family are assessed for safety and dangers are mitigated through safety planning. This speaks to a larger system practice of focusing on the primary issues that brought children and youth to the DCYF's attention, and a need to also include assessment of risk and safety from a family system's approach.

Internal reviews of child protective assessments have shown the monitoring of *Safety Plans* have decreasing trends. The Assessment Practice Reviews have been occurring since 2016 and a total of 731 assessments have been reviewed. Results from 2016 through 2018 demonstrate an average of fifty-four percent (54%) of all assessments were rated as strengths for the thoroughness of the assessment, which includes the accuracy to which dangers were identified. On average thirty-two percent (32%) of the assessments reviewed required a *Safety Plan*, seventy-seven percent (77%) of the *Safety Plans* sufficiently addressed the identified dangers and on average seventy percent (77%) of the safety plans were monitored sufficiently. Reportedly, the lack of sustained attention and tracking of safety plans has contributed to the limited follow through in monitoring safety plans.

Statewide Results	Assessments Reviewed	Safety Plan Needed	Sufficiently Addressed Dangers	Sufficiently Monitored
2016	197	28.93%	91.23%	75.44%
2017	261	27.20%	71.83%	70.42%
2018	273	39.19%	67.29%	64.63%

Figure 1.7: Increased need for safety plans.

Figure 1.7 illustrates the increase in identified safety plans needed, with a significant decline in dangers being sufficiently addressed and a decline in safety plans being sufficiently monitored. This suggests there is a need for improvement in identifying dangers accurately, and secondly ensuring an appropriate plan or service is provided to mitigate the identified dangers. There is no policy on safety planning and there have been limited training opportunities for staff to increase their knowledge and ability around mitigating danger in planning with families.

Safety Strategy 4: (Outcome Item 2 and 3)

CPSWs and JPPOs will develop safety plans that address the ongoing safety of the family and household members and monitor and update them ongoing in both in-home cases (including assessments) and placement cases, especially those where substance abuse and domestic violence is identified.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 6

THEORY OF CHANGE:

CFSR data from the *period under review*, [April 2017 – April 2018] indicated that *Safety Plan*s do not effectively address all dangers, and there is insufficient monitoring of safety plans. Based on scope of work, juvenile justice and child protection do not always define danger in the same manner. For child protection, danger is formally assessed using Structured Decision Making (SDM) tools. In juvenile justice practice, there is a tool used to assess juvenile risk to re-offend, however it does not specifically assess or monitor family safety and there is no formal tool to assess danger. When staff are more experienced and better trained, they are more competent to identify danger and plan for safety. This Strategy will focus on clarifying statute and policy; providing training on how to meet these expectations, and staff demonstration of skills with the support and coaching from their supervisors to assess and offer interventions to all family members. Currently, there are no policies or procedures, which outline steps to take to address identified danger. Through a combination of policy development, provision of specialized trainings, and feedback to staff relative to their practice of safety planning, DCYF theorizes staff will demonstrate improved, timely, and relevant safety interventions with their interactions with families and assessment of dangers. This will be evidenced through an increase to 74% strengths in safety plans sufficiently addressing dangers and sufficiently monitoring safety plans through the Assessment Reviews. Additionally, juvenile justice practice has tradtionally focused their work on the petitioned child

or youth and the parent(s) identified on the petition. *Goal 3, Strategy 1*, shifts engagement practice to include the entire family system. This work begins in the Program Improvement Plan and continues in the *Child and Family Services Plan*, and is important to note as this practice shift will have a positive outcome on safety planning including JJS assessing for risk and safety and providing appropriate interventions through their work with the entire family.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. Create and implement use of policy for *Safety Plans* customized to target identified danger from a safety assessment (informal and/or formal assessment), outline steps for creating a protective and effective *Safety Plan*, and set expectations for how *Safety Plans* are monitored and revised while danger remains present. a) Identify the baseline understanding of staff in differentiating safety/danger and risk. b) Develop agency definition for safety/danger and risk. With direct input from field staff. c) Explore and incorporate effective safety planning practice and policies from other states; d) Create policies specific to safety planning for the whole family for both CPS and JJS to include monitoring safety plans; e) Update the Safety Plan template; f) Review updated policies and forms with supervisors and field staff to support development of a common understanding and expectation in practice g) Integrate the new policies into Core academy training; h) Evaluate and make revisions to policies and forms as necessary	Quarter 2 Quarter 1 Quarter 1 Quarter 1 Quarter 2 Quarter 2 Quarter 3 Quarter 3 Quarter 6	
2. Create/Identify advanced training opportunities in identifying danger and risk (for staff who've already graduated Core Academy) and offer trainings in specialized topics for safety planning.	Quarter 5	
3. Utilize training evaluation data to inform and improve future training content and adjust as relevant a) Formalized feedback loops will support the transfer of learning from policy and specialized trainings :	Quarter 6	

4. Supervisors will coach their staff through developing effective safety plans which include content, that was established through analysis of safety plans that were rated as strengths, as follows: • Content relevant to identified danger; • Plan is created with family; • Identified family supports are engaged and have tasks and/or support monitoring the plan; • Frequency and nature of follow up; • Modifications as needed to continue to mitigate danger (i.e. Responsiveness to causal events); and • Safety plan was put in place for a specific time, etc.	Quarter 4	
5. Safety plans will be evaluated statewide through assessment practice reviews (CPS assessments) and Case Practice Reviews (CPS assessments and CPS and JJS in-home and placement cases). • Areas needing improvements will be discussed in terms of statewide trends with Leadership, as well as with District Offices at the case level in order to support developing practice improvements. • The Assessment Reviews will show 74% strengths for safety plans sufficiently addressing all dangers as long as no more than 40% of assessments require safety plans. • The Assessment Reviews will show 74% strengths of sufficiently monitoring all safety plans. • CPS offices that do not demonstrate a minimum of 74% strength in the area of safety planning will be required to create a strategy to improve safety planning practice in their program improvement initiatives, which are established within one month of their Assessment QA Review. • Juvenile justice and child protective case safety plans will be measured through the PIP measurement plan for Item 3.	-Quarter 5	

Progress to Date

In April 2019, DCYF held their state conference, which highlighted various workshops relevant to New Hampshire's need to improve engagement. Among the workshops included were: *Preparing for and Managing Difficult Interactions* (138 registrants), *Basic De-escalation Skills* (fifty-four registrants), *Domestic Abusers as Fathers and How to Engage Them* (113 registrants), *Nurturing Fathers* (thirty-one registrants), and *Time Management in DCYF Practice* (33 registrants), which highlighted among other great practice, Rochester District Office's daily triage model which Strategy 2 is modelled after. In

February 2019, the Rochester District Office presented their daily triage model to the Intake and Assessment workgroup, which is comprised of representatives from each district office in assessment practice and central intake. The group shared great feedback and energy about the model.

Four full-time case support specialists are currently completing closing tasks on overdue assessments within the following district offices: Southern, Concord, Laconia and Manchester. In addition, part-time case support specialists, who were former child protective employees complete closing tasks on overdue assessments from the remaining district offices and the Special Investigations Unit.

DCYF has been receiving implementation assistance from the *National Council on Crime and Delinquency* (NCCD) over the past year in support of redesigning Structured Decision Making (SDM) tools and revising referral screen-in criteria at Central Intake.

Rapid Safety Feedback completed initial implemented in the final district offices in January 2019, and DCYF celebrated one year since the program's initial implementation in the first offices, in May. Fidelity Reviews conducted by Eckerd report that "the New Hampshire ERSF reviewers continue to demonstrate competency in the teaming model, asking predominantly open-ended questions and allowing the field staff the opportunity to identify safety concerns and make a plan to address them without direction from the reviewers"; and "Improvements from baseline to present have been seen in seven of eight areas being reviewed, indicating positive practice change. The most notable improvements have been seen in questions surrounding utilization of family history in assessment decision-making and the quality of assessment contacts."

Assessment Practice Reviews are conducted monthly, reviewing assessment practice in each district office annually. One continued area of focus has been a review of safety planning practice, and subsequent development of program improvement initiatives with each district office to address *areas needing improvement*.

Finally, in a signing ceremony, Governor Chris Sununu signed Senate Bill 6 into law, which funds fifty-seven front line Child Protective Service Workers (twenty-seven in SFY20, and thirty in SFY21) and twenty supervisors (nine in SYF20, and eleven in SFY21). These additional front line staff will be critical to all aspects of the work, including timely thorough responses to the needs of children, youth and families, ongoing assessments of risk and safety, and attention to closing overdue assessments.

Goal #2: (Permanency)

CFSR OUTCOMES: PERMANENCY OUTCOME 1-2; WELL-BEING OUTCOME 1

Systemic Factors: Case Review System

Improve timeliness to permanency for children and youth with a goal of reunification and adoption for all children in foster care.

For cases reviewed during the *period under review*, [April 2017 to April 2018], New Hampshire received an *area needing improvement* in Permanency Outcomes 1 and 2 (Items 4-11), as well as the Systemic Factor: *Case Review System* (Items 20-24). The CFSR results indicated DCYF has challenges with achieving timely permanency for children with the goals of adoption, reunification, and guardianship. DCYF and the Court were not holding the initial permanency hearings within twelve months of a child coming into care and the timeliness of administrative review meetings, known as FAIR (Family Assessment Inclusive Reunification) meetings, were inconsistent. Further it was determined that Termination of Parental Rights petitions were usually filed later than the federal guidelines. NH Courts schedule hearings 12 months and one day from the Court's finding (or a parent's consent to a finding) of abuse/neglect, pursuant to 169-C: 24-b, I and NH case law.

ROOT CAUSE PROCESS

New Hampshire researched and analyzed qualitative and quantitative data to determine the root cause of the Division's challenge to achieve timely permanency for children with the goal of adoption, reunification and guardianship. Data staff conducted root cause analysis and a deep exploration into the quantitative results and the qualitative narratives for each Item of the On-Site Review Instrument to identify themes in practice that led to the *area needing improvement* ratings. From these themes, problem statements were developed. Subsequently, focus groups were held with DCYF Leadership, FAIR Facilitators, Judicial Stakeholders, Family Service Child Protective Service Workers, Juvenile Justice Permanency Workgroup, DCYF attorneys, CASA, Birth Parent Attorneys and Child Protective Permanency Workers to process "the Five Why's" of the following:

- Accurate client demographic data including home visits, placement data, separation of siblings, and case plan goals are not consistently entered timely in Bridges. Data entered into Bridges is not consistently being monitored for accuracy;
- Primary and concurrent case plan goals are not consistently being established timely;
- Collaboration between DCYF and CIP/Court around DCYF policy and practices is not happening;
- Ongoing efforts are not being made to maintain children's connections, including identifying and/or locating, notifying and evaluating fathers and maternal and paternal relatives; and
- Primary case plan goals are not being consistently addressed throughout the life of the case; concurrent case plan goals are not being worked consistently and concurrently throughout the life of the case.

Possible root causes identified through the focus groups were further evaluated. Data from the statewide automated child welfare information system (SACWIS) known as Bridges was queried to evaluate both child protective and juvenile justice children/youth in placement. The length of time in care, permanency goals and time in care to various points of the permanency process were analyzed with specific attention focused on differences between district offices based on many factors including but not limited to: workload; population demographics; social deterrents, and staffing. Data in the CFSR portal from New Hampshire Case Practice Reviews were also analyzed. Lastly, research of New Hampshire judicial branch about structuring, staffing and scheduling in the family and district courts with the judges, reviewed policy and Medicaid rules were all completed.

The following root causes emerged as contributing factors for New Hampshire's low performance on the permanency outcomes:

- Staff discomfort and skill in facilitating challenging conversations with families (i.e. concurrent planning, engaging absent (now referred to "missing parents")/non-custodial parents and non-petitioned siblings, etc.);
- Practice focuses on the permanency goal, but does not consistently focus on the concurrent goal
- Limited focus on how to concurrent plan in policy and training;
- Lack of access to relevant staff training and comprehensive supervision relevant to permanency; and

These drove the creation of the strategies to improve performance through professional development training, supervisory coaching, protocol development, and collaboration between DCYF, Court Improvement Project and other legal and judicial partners in relation to the following:

- Concurrent planning;
- Identifying and/or locating missing parents;
- Timely permanency hearings and filing of Termination of Parental Rights petitions in order to have timely adoptions; and
- Facilitating challenging conversations with families (addressed through ongoing/advanced training as outlined in *Goal 4: Workforce Development*)

TERMINATION OF PARENTAL RIGHTS/ADOPTION DATA ANALYSIS

In 2008, the National Council of Juvenile and Family Court Judges selected Franklin and Concord courts to become a Model Court, part of a national grant program designed to promote innovative and positive change in child protection proceedings. After the grant program ended, the New Hampshire Model Court Project continued to act as a laboratory, developing and implementing best practice to improve outcomes for children, youth and families. At the onset of implementation, an administrative order was issued by the Administrative Judge that Judges and court staff need to adhere to protocols which were created by the Court Improvement Project and Model Court Project. Child Protection protocols are also incorporated

into DCYF policy, training and practice. The culture within DCYF is strong adherence to protocols and policy. Prior to the implementation of the *2018 Termination of Parental Rights (TPR), Voluntary Mediated Agreement (VMA), Surrender and Adoption* Protocols statewide, it was first piloted in the Model Courts. The court order template previously provided 30, 60 or 90 days for DCYF to file the *Termination of Parental Rights* petitions, which led to longer time in care for children and prolonged permanency. There were discussions that took place about the causes of delay in the related 169-C (abuse and neglect statute) cases while developing the 2018 protocols. Some of the causes are addressed in Strategy 2 and 3, while Strategy 1 focuses on ensuring full implementation of the 2018 protocols and evaluation of the protocols. The protocols provide the following structure:

- Judges are to schedule a 60-day post permanency hearing at the 9-month review hearing, so that if applicable this hearing can be converted to the Termination of Parental Rights preliminary hearing.
- Termination of Parental Rights Petition filed at permanency hearing or within two business days of the permanency order;
- Termination of Parental Rights preliminary hearing/Surrender/Voluntary Mediated Agreement review is held within 60 days of permanency hearing;
- Judges are to schedule the Termination of Parental Rights final hearing within 60 calendar days of the Termination of Parental Rights preliminary hearing;
- If Judges are unable to schedule within the protocol timeframes set forth above, they are to inform the Circuit Court administration so that an assessment may be made regarding a potential shift in judicial resources, dependent on the availability of Judges.
- Termination of Parental Rights final hearing/surrender held and completed within 60 days of the Termination of Parental Rights preliminary hearing;
- Final Termination of Parental Rights order issued (granted or denied) within 30 days of the final hearing;
- If the Termination of Parental Rights petition is granted and no appeal filed, the child is legally freed for adoption; adoption petition will be filed within 30 days [if the child is placed in a pre-adoptive home];
- Adoption finalized within 30 days of the adoption petition being filed;
- If applicable, notice of appeal to the Supreme Court is required within 30 days of the final TPR order. It is estimated Supreme Court appeals are completed within 120 days. The 2018 Protocols are for use in circuit courts only. If there is an appeal, notice is within 30 days, there is an estimated 120 days pendency of appeal;
- Appellate process completed, if Termination of Parental Rights petition is affirmed, adoption is filed within 30 days of child legally freed for adoption; and
- Adoption finalized within 30 days of adoption petition being filed.

The *2018 Termination of Parental Rights, Voluntary Mediated Agreement, Surrender and Adoption Protocols* provide for a child to go through the process of adoption within eighteen months of the finding of abuse or neglect if the Termination of Parental Rights is not appealed. If there is an appeal, the 2018 protocols provide for a child's adoption to finalize within twenty-four months.

In review of data prior to the implementation of the 2018 protocols, 876 children/youth entered care from 2010 through 2017 with a documented date when they were freed for adoption. Timely, accurate, and comprehensive data entry is a challenge for New Hampshire and is addressed under the *Workforce Development Goal, Strategy 3*. Of the children freed for adoption, ninety-six percent (96%) exited care to adoption. For adopted youth, generally, their length of time in care is stable no matter their age when the Termination of Parental Rights occurred or their age when they entered care. Those who were younger are not considerably quicker at exiting than youth who were older. Figure 2.1 shows approximately fifty percent of the children/youth adopted are above and below the blue line showing a slight increase for the time in care, as their age at time of termination increased. The increase may not be statistically significant given the limited population of teenagers (four percent) in the data.

Figure 2.1 also shows the four percent of children/youth legally free who discharged from care with a reason other than adoption or remained in care as of April 12, 2019. This shows a much greater incline for the length of time in care when the child/youth is older at the time of the Termination of Parental Rights. The parental rights were terminated consistently around the same time during a youth's time in care. The mean length of time in care for those children/youth who were adopted was 29.5 months while the median length of time was 28 months.

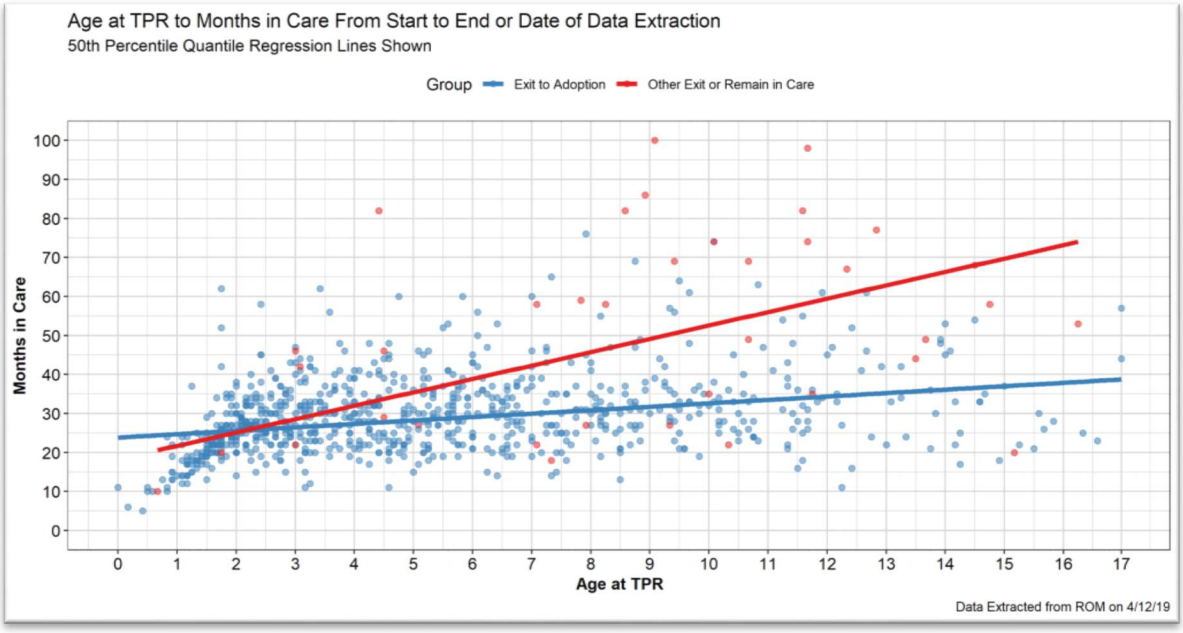


Figure 2.1: Statewide data show no significant difference in length of time in care by child's age at time of Termination of Parental Rights for children adopted (blue line) compared to those who had another exit or remained in care (red line)

The number of adoptions completed in each district office varied and there was a wide discrepancy between the time in care before the child was adopted. For district offices with children who are documented as legally free for adoption, and the child/youth was adopted, in the Keene District Office (population adopted 52), Seacoast District Office (population adopted 50) and Claremont District Office (population adopted 58) the children had longer average time in care to when parental rights were terminated (26 and 25 months). However, all three of those district offices had slightly shorter lengths of time from the child/youth being legally freed to being adopted then the statewide average (6.7 months). The Southern District Office (population 76) had above statewide time in care to Termination of Parental Rights with an average of twenty-four months and had the longest average time between termination and adoption among the district offices at ten and a half months.

Concord and Laconia District Offices had cases heard in the model court sites. The average time from removal to becoming legally free was twenty-two months, and it was an average of 7.6 months from the Termination of Parental Rights to the finalized adoption for children served by Concord District Office (population adopted 68). In Laconia District Office (population adopted 68), the average time from removal to becoming legally free was twenty-three months and an average of 6.3 months from the Termination of Parental Rights to the finalized adoption. Overall, the children/youth who were placed in care from 2010 through 2017, had a documented Termination of Parental Rights date in Bridges and exited care to adoption from the Laconia and Concord District Offices, were in care an average of 29 and 30 months, respectfully. Notably, there is less variability with the distribution of the length of time in care for the children/youth in the Concord and Laconia District Offices as compared to the other district offices statewide. The length of time in Concord does not exceed 57 months for the children adopted and Laconia does not exceed 53 months while the other offices extended to have children in care up to 75 months. Both Concord and Laconia district offices had significant workforce capacity challenges and have cases in multiple courts, which may have impeded further improvement in the timeliness of achievement of adoption. This data showed the pilot of the 2018 protocols in the model court resulted in more timely adoption for the children involved in those district offices over other district offices in the state. Further the concept and expectation behind the protocols ultimately drives for more timely permanency for children.

Permanency Strategy 1: (Outcome Item 6)

DCYF and the Court Improvement Project, Model Court Team, (DCYF, CIP, CASA, Judicial Council, Department of Justice, parent's attorneys, and guardian ad litems) will evaluate the implementation of the 2018 TPR, VMA, Surrender and Adoption Protocols (TPR Chapter) to improve timeliness of TPR process and finalizing adoptions.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 8

THEORY OF CHANGE:

CFSR findings for- Item 6: *Achievement of Permanency Goal* resulted in an *area needing improvement* for cases reviewed during the *period under review* [April 2017- April 2018], as forty-eight percent (48%) of applicable cases rated as a strength indicating problems with timely achievement of adoption. New Hampshire implemented new court protocols around Termination of Parental Rights, adoption, and mediation in 2018. To date, there has been no evaluation of the protocols to determine if they have resulted in an increase in timely filing of Termination of Parental Rights petitions, an increase in timely occurrence of Termination of Parental Rights hearings, and/or timely adoption hearings. It has been theorized that when the Termination of Parental Rights protocols are being followed, this will result in the Termination of Parental Rights hearings held timely, and an overall reduction in time to achievement of adoption. Through shared data and collaboration regarding these data points, New Hampshire believes that with the Division's partners in the CIP Model Court team which includes CIP staff, Judges, CASA, GALs, parent attorneys and DCYF staff the Division will be able to identify if these protocols are effective, and if there are identified problems, efficiently develop system-wide solutions.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. DCYF, Courts and CASA will utilize the following **evaluation plan** to collect and analyze data to evaluate the effectiveness of protocols: a) Data points include:	Quarter 8/Ongoing	

I. Permanency Hearing to Permanency Order[5]; II. Permanency Hearing to TPR Filing; III. TPR Filing to TPR Prelim Order; IV. TPR Filing to TPR Final Order (< 150 days) V. TPR Prelim to TPR Final Order (90 days) VI. TPR Filing to Date of Adoption b) DCYF will collect baseline data broken down by cohorts. The first cohort will include data points one and two beginning October 2019 (for timeframes January 2018- March 2019); c) DCYF will collect data broken down by cohorts on data points four through six beginning in December 2019, and subsequently pulls every six months; Data will be broken down by courts every six months beginning in June 2020. d) The court's data collection system generates a report for data point four on a statewide, annual basis and will continue to do so. A report for data points three and five will be generated manually as able, by the court's data specialist, statewide and annually beginning in May 2019 (by calendar year). e) CASA will bring data on court continuances on a quarterly basis beginning in October 2019, December 2019, then every December and June ongoing. **Cohort 1: Cases that had a nine month review hearing beginning in January 2018*		
2. In order to message to DCYF, CIP, CASA, Judicial Council, Department of Justice, parent's attorneys and guardian ad litems, the evaluation work that is going to be done in the 2018 TPR Protocols, an announcement will be included in the Model Court Highlights (quarterly electronic newsletter provided by the Model Court Team). Members of the Model Court will ensure these updates are communicated to their respective teams.	Quarter 4	

[5] *DCYF pulls the "Date of Order" based on the date the Judge signs the court order.*

3. The Court Improvement Project will seek Administrative Judge approval for changing the court's data point "time to TPR disposition" from 180- days to 150 days (5 months) to align with and more clearly determine whether or not the 150 day protocol standard is being met.	Quarter 1	
4. DCYF will lead in the development of a data sharing plan with Circuit Courts, and CASA to clarify data shared between agencies by June 2020, however aggregate data will be shared earlier, when establishing the baseline.	Quarter 5	
5. The PIP Strategy Sub-committee will review available data on the data points outlined in the evaluation plan from DCYF, Courts and CASA, beginning December 2019, and will share relevant findings ongoing with the CIP and Model Court Team.	Quarter 4	
6. Follow up on data findings will be addressed through the CIP and Model Court Executive Team who will develop an appropriate strategy to address the issue.	Quarter 4	
7. DCYF will develop a performance dashboard for the 2018 TPR Protocols to include Division data, by the end of December 30, 2020 in order to inform supervisors of their progress toward meeting the expectations to move permanency forward for children.	Quarter 5	

CONCURRENT PLANNING DATA ANALYSIS

After reviewing the data from the April 2018 CFSR, which examined cases open between April 2017 and April 2018, as well as 2016 and 2017 Case Practice Review data, it was determined that the type of concurrent plan/goal was not indicative of a rating for a case, but rather concurrent planning was the *area needing improvement*. In the 2018 CFSR, there were seven cases with the goal of guardianship; however, only one where guardianship was the primary goal and this was rated as strength. In the six cases where guardianship was the concurrent plan, one rated as a strength. Three of the cases were rated *areas needing improvement* because neither goal was met timely, if at all, prior to closing. In all five, there was a lack of concerted efforts in concurrent planning resulting in an *area needing improvement*.

In review of the 2016 and 2017 Case Practice Review data, there were twenty-seven cases with a goal of guardianship. In three cases, it was the only case plan goal, and those cases rated as strength for achieving permanency. In the remaining twenty-four cases, guardianship was the concurrent plan with three of the cases receiving an *area needing improvement*. The *area needing improvement* ratings showed lack of concurrent planning but in two of the cases, concerted efforts were not made to achieve the primary goal.

From the 2015 Case Practice Reviews to the 2016 Case Practice Reviews, there was a ten percent improvement in how child protective and juvenile justice services rated in achieving permanency goals. Joint ratings in 2016 were ninety percent (90%) and did not differ significantly between the field services. In 2017, there was a decline in the rating of the achievement of permanency goals in the offices reviewed to seventy-eight percent (78%) strengths of the cases reviewed. Noticeably more child protective cases received ratings of *area needing improvement* for this Item despite an equal sample size from each field service. In review of the narrative reasoning for all ratings of *area needing improvement*, the overarching problems were in concurrent planning and lack of engagement with all caregivers for both child protection and juvenile justice cases in both 2016 and 2017. Six out of the seven cases with a concurrent plan and rated as an *area needing improvement*, rated as such due to a lack of concurrent planning. Other *area needing improvement* ratings with only one permanency plan also rated poorly due to lack of concurrent planning prior to the "current" plan going into effect.

Given the significant lack of concurrent planning, it suggests a problem with staff engagement with families at all levels of case planning necessary to move permanency forward. Focus group discussions revealed there was an overall lack of attention to concurrent planning in both practice and opportunities for case oversight by the courts, through supervision; and mentoring. There was consensus among the various stakeholder focus groups that the root cause for the lack of concurrent planning was due to a lack of experience and training to engage families in difficult conversations. Interestingly, judicial stakeholders also reported feeling they needed more support in having transparent and conversations with families, particularly challenging around concurrent planning. Further, staff struggle with prioritizing tasks on their workload, making the time to concurrent plan and there is a lack of focus on concurrent planning during supervisions and Court hearings. The workforce development goal, Strategies 1 and 2 will address challenges with supervisory support and training to engage families in difficult conversations. A lack of collaboration between CPSWs and others, who can help move the case plan forward, such as birth parent attorneys, was also described as a barrier to timely permanency and concurrent planning. There is no consistent or written expectation on how to concurrent plan with various participants in the case. There was also a strong theme representing that bias of various parties to the case, influence conversations and case planning. The misalignment of values around what is appropriate to discuss, when it is appropriate to discuss concurrent plans and with whom the conversations should be held was evident during focus groups. This data and root cause drive Strategy 2 for concurrent planning.

Permanency Strategy 2: (Outcome Items: 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 16, 17, 18)

Children and youth in foster care will achieve timely permanency through improved and sustained attention on concurrent planning efforts, including exploring as systems when it is most appropriate to utilize legal guardianship as a permanency plan.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 3

THEORY OF CHANGE:

During the *period under review*, [April 2017-April 2018], CFSR findings for Item 6: *Achievement of Permanency Goal* resulted in a strength for forty-eight percent (48%) of applicable cases. Root cause analysis indicated problems with untimely permanency due to:

- Concurrent planning being done consecutively, not concurrently;
- Concurrent planning not consistently being addressed in court hearings; and
- CPSWs, JPPOs, CASAs/GALs and Judges struggling with having conversations about concurrent planning with youth, fathers, mothers, foster parents and relative caregivers.

DCYF and the Model Court/CIP is in the process of updating the 2003 abuse and neglect protocols, including the development of a new chapter on concurrent planning. However this protocol will not likely be complete and ready for implementation during the PIP reporting period. In the interim, there is a need to create a common understanding of the expectations for concurrent planning practice and a level of accountability with having early and frequent conversations about concurrent planning (i.e. during supervision, court hearings, Family Assessment Inclusive Reunification meetings, and other case planning processes). Additionally, due to limited foster care placement resources, there is a need to improve the identification, assessment and engagement of relative caregivers as viable placement resources whether temporary or longterm.. It has been theorized that establishing clear expectations for concurrent planning, training and tools to support these conversations with families, along with working together to identify and resolve adaptive challenges both in the agency and judicial community will result in first, an overall system shift in working both permanency plans with the same urgency, and secondly, DCYF, CIP, Judicial Council and CASA exploring as systems when it is most appropriate to utilize legal guardianship as a permanency plan. This will result in an overall reduction in timeliness to permanency.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. DCYF will collaborate with the CIP and Model Court Team around the development of DCYF's concurrent planning policy which will include the use of guardianship with a fit and willing relative, as a	Quarter 2	

permanency plan, to ensure consistency across the child welfare system.		
2. The Court Improvement Project (CIP) will support DCYF's practice changes around concurrent planning by requesting the Administrative Judge issue a memo to Judges overseeing all 169-B, C and D cases, advising them to inquire at all review hearings as to DCYF's efforts and barriers to implement a concurrent plan for children in out of home placement.	Memo: Quarter 1 Inquiry: Ongoing/ Quarter	
3. Develop concurrent planning policy/standards of practice for both CPS and JJS which includes: a) Identify the purpose of concurrent planning (i.e. timely permanency, engaging parents and extended family) b) Define concurrent planning as a simultaneous process to achieve timely permanency; that engages parents and develops relationships between parents and foster/relative caregivers; and clearly outlines that a concurrent permanency plan will be implemented if the permanency plan cannot be finalized timely. c) Identifies the different concurrent plans (i.e. adoption, guardianship with a fit and willing relative, APPLA) d) Includes youth voice when developmentally appropriate (i.e. APPLA and guardianship with a fit and willing relative) e) Instructs on the statutory timeframes for establishing a permanency and concurrent plan. f) Outlines considerations when recommending a concurrent plan (i.e. age of child/youth, child's wishes for permanency, relatives considered, concurrent plan is with relatives, etc.). g) Establishes an expectation that when guardianship is chosen over adoption as the concurrent plan, a discussion will be documented (i.e. PPT notes; court reports) h) Outlines when concurrent planning should begin, the frequency of discussions and who should be involved i) Identifies when the concurrent planning brochure needs to be re-reviewed with families (i.e. when a permanency goal is expected to change) j) Identifies implementing the concurrent plan when it is unlikely reunification is going to occur such as in the case of abandonment; parent expresses intention to surrender, at or close in time to the permanency hearing, etc.) and how to process that recommendation. k) Identifies that when a more preferred permanency plan is no longer viable, the identified concurrent permanency plan will be become the new preferred permanency plan; and, it	Quarter 2	

will be documented why other preferred goals are not applicable.		
4. Develop a brochure that outlines the stages of concurrent planning from placement through the Permanency Hearing. a) CPSWs and JPPOs will utilize the brochure as a tool to discuss concurrent planning with birth parents, children/youth, foster parents and relative care providers (initially and ongoing; and when there is a change in permanency goal). b) CPSWs and JPPOs will identify the permanency and concurrent plan that will be proposed to the court, on the brochure; and will leave the brochure with families. c) CPSWs and JPPOs will have families sign the acknowledgement panel indicating that they have been involved in identifying the permanency and concurrent case plan goal that will be proposed to the court, and/or CPSWs and JPPOs will document a family's refusal to participate in this conversation.	Quarter 2	
5. DCYF will utilize the Youth Information Sheet (formerly "Family Inquiry Tool") and Relative Notification Letter to identify, locate and engage and assess paternal and maternal relatives for placement in preparation for each hearing (Dispositional hearings-through Post Permanency hearings as appropriate.) a) Recognizing that birth parent attorneys provide independent legal representation to their clients, DCYF will work with the Judicial Council to provide resources* to support these attorneys in identifying relatives (including contact information) with parents. Birth parents and/or their attorneys, will have the option of updating this information at every hearing. b) DCYF in its court report, will summarize efforts to assess the viability of a relative(s) as the child /youth's concurrent plan of adoption, guardianship, or APPLA * Education around the benefits of gathering this information for children, youth and families	Quarter 2	
6. Train new and seasoned staff on: a) New concurrent planning policy/standards of practice; b) How to use concurrent planning brochure to reinforce concurrent planning conversations with families; and c) DCYF leadership will encourage participants to discuss their thoughts/concerns in order to best support an agency shift in practice with respect to use of guardianship as a permanency plan.	Quarter 3	

7. The brochure will also be made available to: a. Parent attorneys to be used in their conversations about concurrent planning with parents; and b. CASA GALs/GALs to be used in their conversations with children/youth about concurrent planning efforts planned for the family.		
8. DCYF will incorporate new concurrent planning policy and standards of practice into Core Academy curriculum for both CPS and JJS practice in support of caseworkers developing and transferring skills on how to develop and work an effective concurrent plan and how to have those conversations routinely with children/youth and families.	Quarter 3	
9. DCYF will improve the service delivery and family engagement relative to Family Assessment Inclusive Reunification (FAIR) service to ensure a facilitated conversation specific to safety, permanency, concurrent planning, and well-being are being held with families at all meetings. a) Identify a more effective process for informing families about the FAIR process and inviting critical individuals (including the Permanency Worker when available) to the CPS 10-day FAIR meetings. b) Revise FAIR policy to reflect: I. development of individual or family level objectives (ILO/FLO) and/or action plans which outline what the family must start doing to work toward goal of reunification; II. Identification of the permanency and concurrent plan at the first FAIR meeting; III. Expectation the family and supports will be engaged in a conversation about both goals (progress and barriers) at every FAIR meeting; IV. Identification of resources and supports that can support moving the case plan forward beginning at the initial, and subsequent ongoing FAIR meetings; V. Identify expectations for ensuing all FAIR elements are covered when meetings are held jointly with another agencies treatment meeting (i.e. entire family composition is included) c) Train Fair Facilitators on changes to FAIR policy/standards of practice.	Quarter 3	

d) Roll Out: Test changes in one to two offices (i.e. offices that join assessment and family services early), before rolling out statewide. l) Identify and implement a plan to evaluate the effectiveness of the FAIR service. (i.e. FAIR meeting surveys with questions about concurrent planning, FAIR meeting observations, case review of FAIR meeting notes, data collection of case outcomes, data collection of meeting dates, trending data on number of cases with the different permanency goals)		

IDENTIFYING, LOCATING, AND ENGAGING MISSING PARENTS DATA ANALYSIS

The lack of identifying, locating, and engaging absent parents identified as a cause for delayed permanency through discussions while developing the 2018 protocols referenced above. There has been a lack of consistent efforts to identify, locate, and engage absent parents early and ongoing, which can negatively affect permanency for children in care. The Case Practice Reviews in 2016 and 2017 had 133 cases applicable for Item 12B: *Needs Assessment and Services to Parents* with seventeen percent (twenty-three) of those cases having at least one absent parent. Almost half of the cases (twelve) with an absent parent received a rating of *area needing improvement*. The Case Practice Review sample consisted of sixty-three percent (63%) foster care cases, which represents those cases working towards permanency. Absent parents in the foster care cases verses in-home cases represented a similar proportion, meaning sixty-five percent (65%) of cases involving an absent parent are foster care cases. However, when looking at the data concerning the *area needing improvement* ratings with absent parents, more of those cases were foster care. This indicates when there is an absent parent a higher likelihood of that parent not being engaged if it is a foster care case. In review of Item 6 of the OSRI, the absent parent cases receiving an *area needing improvement* more frequently on Item 12B, and youth were in care longer at the time the review was conducted, than the cases with the absent parent receiving a strength on Item 12B (figure 2.2).

	Absent Parent 12 B Area Needing Improvement	Absent Parent 12 B Strength	Difference
Average Time in Care	16	9.6	6.4
Median Time in Care	14	10	4

Figure 2.2 *Data Source: CFSR Portal Item 12B and 6, question A2*

From January 1, 2015 through December 2018, 822 child protective cases opened and remained open for more than 45 days in which it would be presumed that if there were an absent parent in the case, the CPSW would be attempting to identify and locate that parent. One hundred and sixty-five (165) cases had at least one contact date indicating an attempt to contact an absent parent (i.e. Accurint search, absent parent affidavit, letters, law enforcement, internet, etc.) completed with an average of 1.7 dates per case. The median was one date per case but there was a range from one to twelve dates per case indicating some type of search/attempt to contact. If the 2016 and 2017 Case Practice Reviews accurately resemble the proportion of absent parents in cases, then seventeen percent of the cases open would potentially have an absent parent. Although it would appear at least one attempt was made to identify and locate the absent parent a larger concern was the length of time it took to attempt to locate the absent parent. The average length of time from the date the case opened to the first documented attempt to contact the absent parent was 177 days with a median of 132 days.

If no attempt to locate the absent parent is made until four months into the case, this may prolong permanency when the parent is located and engaged. The earlier a parent is located, the more quickly DCYF can engage with that parent for the safety, permanency and well-being of the child(ren). The third

Strategy will focus on identifying and locating absent parents from the start of the case through collaboration with the court, birth parent attorneys and CASA. This Strategy compliments the *Goal 4: Workforce Development, Strategy 2* as well as *Goal 3: Engagement*, Strategy 2.

For the children/youth reported above for Strategy 1 who entered care between 2010 and 2017 the date of the Termination of Parental Rights for the mother and the father were each reviewed. Approximately sixty-one percent (61%) of the children had the same date for termination for the mother and father which leaves almost forty percent (41%) that may be on different tracks due to delays in identification, location, and engagement of absent parents. Figure 2.3 shows the percentage of termination dates on the same day by year the child entered care.

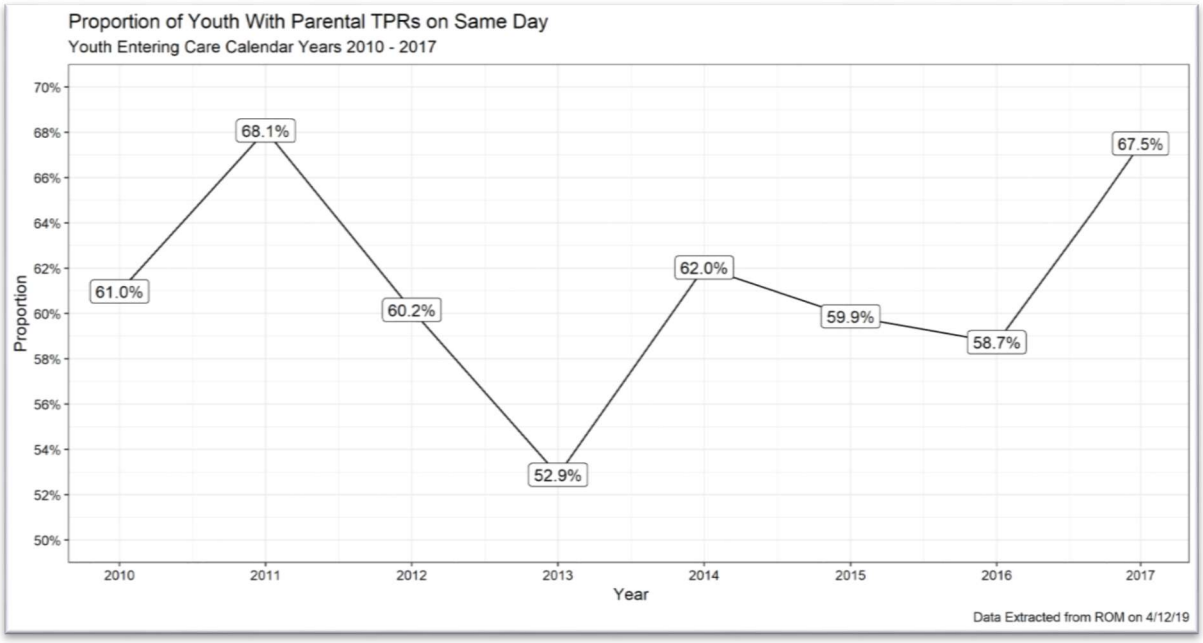


Figure 2.3: No more than 68% of children/youth had the same termination of parental rights dates for both parents in any given year they entered care.

Permanency Strategy 3: (Outcome Items: 2, 3, 4, 6, 8, 9, 10, 11, 12, 13, 15)

Children and youth in foster care will achieve timely permanency through increased and sustained attention on identifying, locating and engaging missing parents and identifying the child's relative connections.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 4

THEORY OF CHANGE:

During the *period under review* [April 2017-April 2018], CFSR findings for Item 15 *Case Worker Visits* with mothers was rated at fifty-one percent (51%) strengths. Case worker visits with fathers was rated at twenty-nine percent (29%) strength indicating problems with delayed achievement of permanency due to lack of engagement with parents, or missing parents not being identified and/or located, and engaged early and ongoing. CPSWs, JPPOs and judicial stakeholders struggle with having conversations with the primary parent about identifying, and engaging the missing parent in case planning. DCYF begins efforts to identify, locate and engage parents prior to the court becoming involved. The underlying root cause of a lack of engagement with parents is staff skill and comfort with facilitating difficult conversations (as referenced in Goal 3: Engagement), particularly with a primary parent or youth when trying to identify and engage a "missing" parent. DCYF has begun offering different training opportunities for staff to engage in a variety of difficult conversations with families, discussed in Goal 4: Workforce Development Strategy 2. It has been theorized that with increased training and coaching, CPSWs and JPPOs will develop more skill and confidence in building rapport with families and inquiring about efforts and barriers to identify parent #2. The development of court protocols will create a common understanding and expectation for what happens once a missing parent is identified and located. This further creates a level of accountability for compliance with expectations for all parties. With this common expectation, Judges will have clarity around their role in monitoring DCYF's efforts to identify and locate missing parents, DCYF's role in engaging those parents in case planning and the court's role in engaging those parents in subsequent court proceedings. Once a missing parent is identified and/or located, the missing protocols only apply when DCYF does not file an abuse or neglect petition against the parent – that is, the parent's status is of a non-accused parent. While the protocols don't use the language of courts "engaging parents", they are written to focus on the court process that includes ensuring missing parents who have been located and/or identified are served and, if paternity is established, are promptly joined to the accused parent's case. The protocols also ensure courts schedule and hold a prompt court hearing for these parents, at which the court reviews the Acknowledgment form, including the sections about a parent's statutory right to request a parental fitness hearing and physical custody of his/her child(ren). The protocols ensure these parents receive notice of any scheduled 169-C hearings in the accused parent's case. When parents are identified and engaged earlier in the case, it will result in improvement in timely permanency and/or reunification within twelve months, identification and consideration of placement with a relative.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
IDENTIFYING AND LOCATING MISSING PARENTS:		
1. Through training centered upon building skill with engagement and communication and through practical application, CPSWs and JPPOs will build trust, rapport and investment in their relationships with families by building a culture of safety to engage in these difficult conversations. a) CPSW and JPPOs will clearly explain their role and expectations for ongoing work. • Help to dispel fear around the "unknown" for families by clearly explaining the purpose for why they are asking about identifying the missing parent and what they will do with that information. • Supervisors will help to dispel fear around the "unknown" for CPSWs and JPPOs during supervision (i.e. what happens to the case if the Division locates/engages absent parent?)	Quarter 2-Quarter 4 Conversation: Ongoing/ Quarter 4	
2. DCYF will enhance the use of alternative sources (other than asking Parent 1) to locate Parent 2, including: a) CPSWs and JPPOs may utilize and document the search criteria identified within DCYF's Affidavit to Identify and/or Locate a Parent, Legal Guardian or Putative Father to locate the missing parent. b) CPSW's will submit the Affidavit before every 169-C court hearing that has a missing parent, as set forth in the protocols. c) Supervisors oversight to ensure that CPSWs and JPPOs are addressing both parents in all court reports and submitting the affidavit before every court hearing;	Ongoing/ Quarter 4	
3. DCYF and the Court Improvement Project (CIP) and Model Court Project will develop protocols that set forth the role and responsibilities of the court at RSA 169-C hearings regarding DCYF's efforts to identify and/or locate a missing parent and submit before each hearing the *Affidavit to Identify and/or Locate a Parent, Legal Guardian or Putative Father*. a) The protocols will define "efforts" to identify and/or locate a missing parent and for how long the efforts are required to be made. b) The Court Improvement Project and Model Court Project will consider each system's capacity to support and sponsor both	Quarter 1	

an initial training, ongoing protocol training and evaluation efforts; as well as CIP's resources, availability of staff and consultants and funding when determining if these protocols will be implemented statewide or piloted in a model court site. c) Explore the possibility of an online training delivery.	Quarter 1	
4. The CIP and MCP will review and make any necessary changes to the *Acknowledgement of Possible Consequences to Parental Rights in Abuse and Neglect Cases* form to include information about identifying and/or locating the missing parent.	Quarter 2	
5. At all 169-C hearings, the Court should ask the parties if anyone knows the name and or address of the missing parent and his or her relatives. If known, the Court should instruct the parties to inform DCYF.	Quarter 2	
6. The court will oversee DCYF's efforts to identify and/or locate a missing parent by reviewing with DCYF, at every 169-C hearing, the Affidavit in which DCYF describes its efforts to date to identify and/or locate a missing parent, as well as what efforts have been made to engage the missing parent in court proceedings.	Quarter 2-4	
ENGAGING MISSING PARENTS:		
7. DCYF and the Court Improvement Project (CIP) and Model Court Project will develop protocols that set forth the role and responsibilities of the court at every RSA 169-C hearing regarding missing parents so that, once a parent is identified and/or located, the parent is served and, if paternity is established, are promptly joined to the accused parent's case.	Quarter 1	
8. The CIP and Model Court will revise the *2003 Bill F*[6]*. Hearing protocols (Parental Fitness Hearing)* to reflect the requirements of RSA 169-C.	Quarter 1	

[6] *In 2000, New Hampshire Supreme Court established case law, which prompted the establishment of procedures for parents who have not been charged with abuse or neglect to be afforded, upon request, a full hearing regarding their ability to obtain custody of their child. During the hearing, a parent must be provided the opportunity to present evidence pertaining to his or her ability to provide care for the child. Unless the State demonstrates by a preponderance of the evidence, that he or she has abused or neglected the child or is otherwise unfit to perform his or her duties, the parent shall be awarded custody of the child.*

9. DCYF will develop and implement the use of a brochure that, in addition to the parent's right to request a *Parental Fitness Hearing*, explains the purpose and nature of the *Parental Fitness Hearing*.	Quarter 1	
10. DCYF develop revised policies *1173 Engaging A Non-Custodial Parent During An Assessment* and *1505 Efforts With Absent/Non-Custodial Parents During A Case* to align with court protocols for Child Protective and Juvenile Justice Services.	Quarter 1	
11. When a missing parent is identified, but does not have custody, DCYF will complete and/or update the *Youth Information Sheet* (formerly "Family Inquiry Tool") to identify, locate, engage, and assess paternal and maternal relatives who may be able to provide a safe and stable placement while the child(ren)/youth remain in care.	Quarter 2	
12. In order to implement the new and revised protocols, the Court Improvement Project and Model Court Project will: coordinate with DCYF, CASA, the New Hampshire Judicial Council and GAL board to develop and deliver initial trainings for courts, DCYF, CASA GALs/GALs, parent attorneys and service providers, including foster parents, on the revised protocols, and updated court orders. Although the protocols will apply to 169-C cases, JPPOs may be invited to participate in these trainings.	Quarter 2 Quarter 2	
13. DCYF, CIP and Model Court will seek technical assistance as needed to develop an evaluation tool to determine the effectiveness of the submission of the Affidavit by DCYF and the colloquy by the Court.	Quarter 2-Quarter 4	
14. DCYF will evaluate the effectiveness of submitting the Affidavit prior to every 169-C hearing.	Quarter 2-Quarter 4	

Progress to Date

DCYF and CIP have begun to gather data to evaluate the *2018 Termination of Parental Rights, Voluntary Mediated Agreement, Surrender and Adoption Protocols*. In November 2018, CIP accessed technical assistance from the Capacity Building Center for Courts to develop a tool from which they would conduct case reads of adoption cases in three courts.

Since December 2018, the Model Court team has been meeting to develop new protocols to address identification, location, and engagement of missing parents. Protocol development, and system-wide conversations about practice successes, challenges and barriers have driven decision making on the development of these protocols.

In April 2019, a team comprised from Model Court members attended the State Team Planning Meeting in Washington DC, and co-developed a new strategy to address the need for a high quality legal representation program for parents post-petition, led by the Judicial Council and managed by the Model Court Executive Committee. This has been included in the *2020-2024 Child and Family Services Plan*

Also in April 2019 DCYF held their state conference, which highlighted various workshops including: *Preparing for and M*anaging *Difficult Interactions* (138 registrants), *Domestic Abusers as Fathers and How to Engage Them* (113 registrants), *Nurturing Fathers* (thirty-one registrants) as well as *Concurrent Planning* (forty-five registrants).

Goal #3: (Engagement)

CFSR OUTCOMES: SAFETY 1; WELL-BEING 1-3

Systemic Factors: Case Review System

Strengthen engagement with all parents; especially fathers, and all children/youth in the home in quality caseworker visits and case planning.

For cases reviewed during the *period under review* [April 2017 to April 2018], New Hampshire received an *area needing improvement* in Well-Being Outcome 1 (Items 12-15), and the *Systemic Factor*: *Written Case Plan* (Item 20). Throughout the CFSR process it was noted that the lack of engagement with all children and parents, particularly fathers, impacted DCYF's ability to assure safety of all children in the home, assess and address the needs of both children and parents, involve and place children with relatives, case plan, and among other things, achieve timely permanency. It was found DCYF needs to connect meaningfully with all of the children in the family and with all the children's caregivers, especially fathers. It was also established that case plans tend to be generic, and that true family voice was lacking when generating plans.

ROOT CAUSE PROCESS

New Hampshire researched and analyzed qualitative and quantitative data to determine the root cause of the Division's challenge to engage actively all parents in case planning in order to achieve safety, permanency, and well-being for children. Data staff conducted root cause analysis and a deep exploration into the quantitative results and the qualitative narratives for each Item of the On-Site Review Instrument to identify themes in practice that led to the *area needing improvement* ratings. From these themes, problem statements were developed. Subsequently, focus groups were held with Judicial Stakeholders, Family Service Child Protective Service Workers, Juvenile Justice Policy Workgroup, DCYF attorneys, CASA, Birth Parent Attorneys and Child Protection Permanency Workers to process "the Five Why's" of the following:

- DCYF is not seeing and assessing all children; only the identified child is seen ongoing;
- Case planning is not done collaboratively with all parents or other caregivers in the household even when parents are engaged;
- Case planning is not done collaboratively with all children in the family;
- All caregivers, especially fathers are not being assessed to ensure the safety of their children; and
- Ongoing efforts are not being made to maintain children's'/youth's connections, including identifying, notifying and evaluating fathers and maternal and paternal relatives.

Possible root causes identified through the focus groups were further evaluated. Data from the statewide automated child welfare information system (SACWIS) known as Bridges was queried to evaluate contacts with parents, parental attendance at meetings and service authorizations in both child protection and juvenile justice cases. Specific attention was focused on differences between district offices based on many factors including but not limited to: workload; population demographics; social deterrents; and staffing. Data in the CFSR portal from New Hampshire Case Practice Reviews were also analyzed.

The following root causes emerged as contributing factors for New Hampshire's low performance on the CFSR outcomes:

- Misalignment of staffs' values to work with both parents equally and all children in the family;
- Lack of good engagement skills especially around challenging conversations with both parents equally and consistently;
- Compassion fatigue of the staff interfere with practice; and
- Lack of understanding of the family dynamics.

These drove the creation of the strategies to improve performance in relation to the following:

- Engagement of all parents as well as all children involved in the family not just the petitioned youth;
- Improve identification and engagement of fathers.

CHILD/YOUTH, FATHER AND MOTHER ENGAGEMENT DATA ANALYSIS

In calendar year 2016 and 2017, DCYF held Case Practice Reviews in seven district offices reviewing 141 cases (82 and 59 respectively) in those offices. The data have shown signs of rising *areas needing improvement* between 2016 and 2017, especially for fathers and children when the focus is around engagement. The tables below provide the percentages of cases that were scored as an *area needing improvement* out of the total applicable cases for various Items in the On-Site Review Instrument as well as the rate change between the two years. The Figure 3.1 references Item 12: *Needs and Services of Child, Parents and Foster Parents*. This Item assesses the Division's efforts to conduct formal or informal initial and/or ongoing comprehensive assessment that accurately assessed the needs of the child(ren), mother and father and whether appropriate services were provided to meet the identified needs of each.

ITEM 12 AREA NEEDING IMPROVEMENT			
	2016	2017	Rate Change
Child(ren)			
Assess needs initial and/or ongoing	6.1%	10.2%	4%
Provide services to meet needs	6.9%	8.8%	2%
Mother			
Assess needs initial and/or ongoing	6.7%	5.8%	-1%
Provide services to meet needs	8.2%	11.4%	3%
Father			
Assess needs initial and/or ongoing	31.3%	37.5%	6%
Provide services to meet needs	31.1%	47.2%	16%

Figure 3.1 *Data Source: CFSR Portal*

As can be seen, children and fathers show an increase in the proportion of cases receiving a negative rating between the two years for comprehensive assessment of needs. The Division showed an increased challenge to provide services to meet the needs of the child(ren), mother and father; however, the father having the most significant rate change.

Figure 3.2 references Item 13: *Child and Family Involvement in Case Planning*. This table clearly shows a decline in efforts to actively engage the entire family from 2016 to 2017, with the most significant decline in engagement being with fathers.

ITEM 13 AREA NEEDING IMPROVEMENT			
	2016	2017	Rate Change
Child	8.3%	19.2%	11%
Mother	5.4%	10.0%	5%
Father	24.2%	35.1%	11%

Figure 3.2 *Data Source: CFSR Portal*

Two other areas worth exploring from the Case Practice Review results are the *Frequency and Quality of Visits with Child(ren) and Parents* (Items 14 and 15). The data from these two *Item*s most significantly show the need for improved engagement between the juvenile justice probation and parole officer and the child protective service worker with the child, mother and father. The increase of *area needing improvement* in these Items is high. For children, the rating for quality changes almost twice as much as the frequency for negative response showing that although visits may be happening the engagement with the children/youth was not sufficient to address issues pertaining to safety, permanency and well-being and promote achievement of case goals. Whereas the frequency of the visits with the father were not sufficient; when visits did occur, the quality of the visits did not decline as significantly as the frequency.

ITEMS 14 AND 15 AREA NEEDING IMPROVEMENT			
	2016	2017	Rate Change
Child(ren)			
Frequency	3.7%	10.2%	7%
Quality	8.5%	22.0%	13%
Mother			
Frequency	12.2%	24.0%	12%
Quality	5.6%	16.7%	11%
Father			
Frequency	26.7%	51.4%	25%
Quality	19.2%	35.7%	16%

Figure 3.3 *Data Source: CFSR Portal*

Overwhelmingly, the Case Practice Review data shows a rise in the rate of change for the proportion of *areas needing improvement* present across all of the Items for the child/youth and the father and for most of the Items for the mother. It was clear through the stakeholder focus groups that complexity of family structures, and the staffs' lack of understanding of the expectations around which parents and which children are required to be seen, on a monthly basis prohibited good family engagement. It appears there is increased confusion when there is more than one household, when non-petitioned siblings are involved, particularly when they do not reside in the primary household, or when involving the non-accused parent of a sibling who visits the family home. This lack of clarity highlights a need for further explanation around expectations for engaging all children and parents. Additionally, some staff feel uncomfortable with having transparent or challenging conversations, such as discussing concurrent planning options with families, or struggling to

maintain a balance between being engaging and being assertive when a parent refuses to work with DCYF in identifying or engaging another parent. Further, staff have misconceptions about fathers usually based on what others have represented, and some may not have a clear understanding on how to engage them effectively. An element of this strategy will focus on training that will assist staff to build their engagement skills with families and facilitating difficult or challenging conversations with families.

Engagement Strategy 1: (Outcome Items: 2, 3, 6, 12, 13, 14, 15, 16, 17, 18)

Develop a culture of practice where JPPOs and CPSWs engage all parents and all children, evaluate and monitor the entire family for safety and risk in order to reduce and/or prevent future involvement with the Division.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 8

THEORY OF CHANGE:

CFSR data for the *period under review* [April 2017-April 2018], *Items 14 and 15: Caseworker Visits with Child, Mothers and Father* rated at sixty-three percent (63%) strength for children, fifty-one percent (51%) strength for mothers and twenty-nine percent (29%) strength for fathers, indicating a lack of engagement with families, particularly fathers. This impacts DCYF's ability to conduct initial and ongoing quality risk and safety assessments for all children in the home primarily in juvenile justice, but also present in child protective cases. Through further exploration of this problem, DCYF identified that there are clear expectations for contact with petitioned youth in both child protective and juvenile justice cases; however, those expectations are not clear when it comes to siblings or other children in the household. Likewise, expectations for engaging all parents is not clearly outlined. Engaging all children and all parents has been an expectation in child protection, where this is relatively new in juvenile justice, but engagement overall is problematic in both field services. DCYF theorizes through establishing practice expectations; assessing readiness for change; delivering training and policy needs; messaging practice changes both internally and externally; and working collaboratively with birth parent leaders at all levels within the Division, a shift in practice to have more consistent engagement of all children and all parents with both child protective and juvenile justice families will occur. This will be evident through documentation; Case Practice Review related interviews with families; and the referrals for services and participation with community home-based providers reflecting the family systems approach.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. DCYF Administration, with feedback from field workers will establish consistent guidelines to define: a) Who is a parent; and	Quarter 1	

b) Who is a child, relevant to the practice of engaging all parents and all children; c) Minimum frequency of contact between CPSWs and parents and CPSWs and children; d) Methods for informal assessment of risk and safety in both child protection and juvenile justice cases		
2. Obtain feedback to identify additional considerations and/or clear barriers that will need to be overcome in order to initiate practice change, particularly in juvenile justice cases.	Quarter 1	
3. Guidelines will be reflected in relevant policies and agency trainings.	Quarter 2	
4. Revise and implement all relevant policies relative to frequency and quality of contacts between workers and parents; and between workers and children for both child protective and juvenile justice cases. a) DCYF will work with the Courts to share the above referenced DCYF policies with Courts and Judges with a reminder of what is in the Statute around parental responsibility in support of JPPOs and CPSWs having more success engaging and working with the entire family.	Quarter 2	
5. In conjunction with the release of new policies, DCYF Administration will message expectation for juvenile justice and child protection that monthly concerted efforts will be made to engage all parents and all children to assess the risk and safety of all family members including siblings: a) Contact will be face-to-face, in the home when children are residing in the home and/or are visiting the home. b) Contact with children/youth will be face-to-face, in the placement when children are placed outside their home; c) When no children reside in the home, or visit the home, quality contacts with parents are encouraged through face-to-face interaction which may occur outside the home (or other means such as: face time/skype calls). d) Identify what practice should be included in their assessment of child/youth and parent needs (i.e. safety, permanency and wellbeing – educational, physical health and mental health/substance abuse treatment needs)	Quarter 3	
6. Increase discussions and buy-in for practice change at all levels, through:	Quarter 3- Quarter 8	

a) Administrators will facilitate practice conversations with supervisors to support coaching their staff around new practice expectations. b) Supervisors will promote engagement of all children and parents through facilitated conversations with their staff that identify and demonstrate the importance of involving the entire family.		
7. Offer training which empowers staff to self-evaluate their engagement styles, and encourages them to identify areas in which they need to grow and expand their skills and learn new tools in areas such as: a) How to use the Social Discipline Window to determine how to most effectively manage an interaction; or b) How to build rapport and consensus with families from the onset (Permanency Strategy #3); or c) How to separate intention from actions, identify and build upon family strengths; identify challenges within everyday life situations; or d) How to effectively engage a disengaged parent or youth; or e) How to facilitate a conversation supporting the connection between engaging all children and all parents and prevention/recidivism rates; or f) How to communicate and effectively utilize their role and authority as a JPPO/CPSW to assess the risk/safety/needs of all children and all parents; or g) How to conduct a quality visit with all parents, and siblings and how to document a quality visit; or h) Shared success stories from JPPOs, CPSWs and parents who were able to engage all children effectively and parents on open cases will be incorporated into staff and supervisory trainings.	Quarter 3-Quarter 4	
8. Continue to promote JPPO and CPSW participation in events such as: *Better Together with Birth Parent*s Workshops, which create an experience for DCYF staff and families to learn through sharing their personal experiences working with DCYF, and use of *Better Together with Birth Parents* data to inform practice.	Ongoing through Quarter 8	

9. JPPOs and/or CPSWs will facilitate referrals to mitigate risk and/or restore safety for all children and parents as needs are identified, as identified in initial and ongoing risk and safety assessments.	Ongoing through Quarter 8	
10. Progress on this Strategy will be measured as determined through the approved measurement plan.	Quarter 5	

PARENTAL PARTICIPATION IN CASE DATA ANALYSIS

During focus groups it was identified that there is a belief that fathers are a poor influence or do not want to engage which creates barriers for staff to engage with him. However, data analysis of caregiver strengths and needs assessments, generally, found there is no significant conclusion that fathers have more needs than mothers. Qualitative research and data analysis found that mothers overwhelmingly receive the majority of all parental contacts relative to fathers. The proportions for mothers and fathers in contacts were estimated statewide during state fiscal year 2018 as shown in figure 3.4 below.

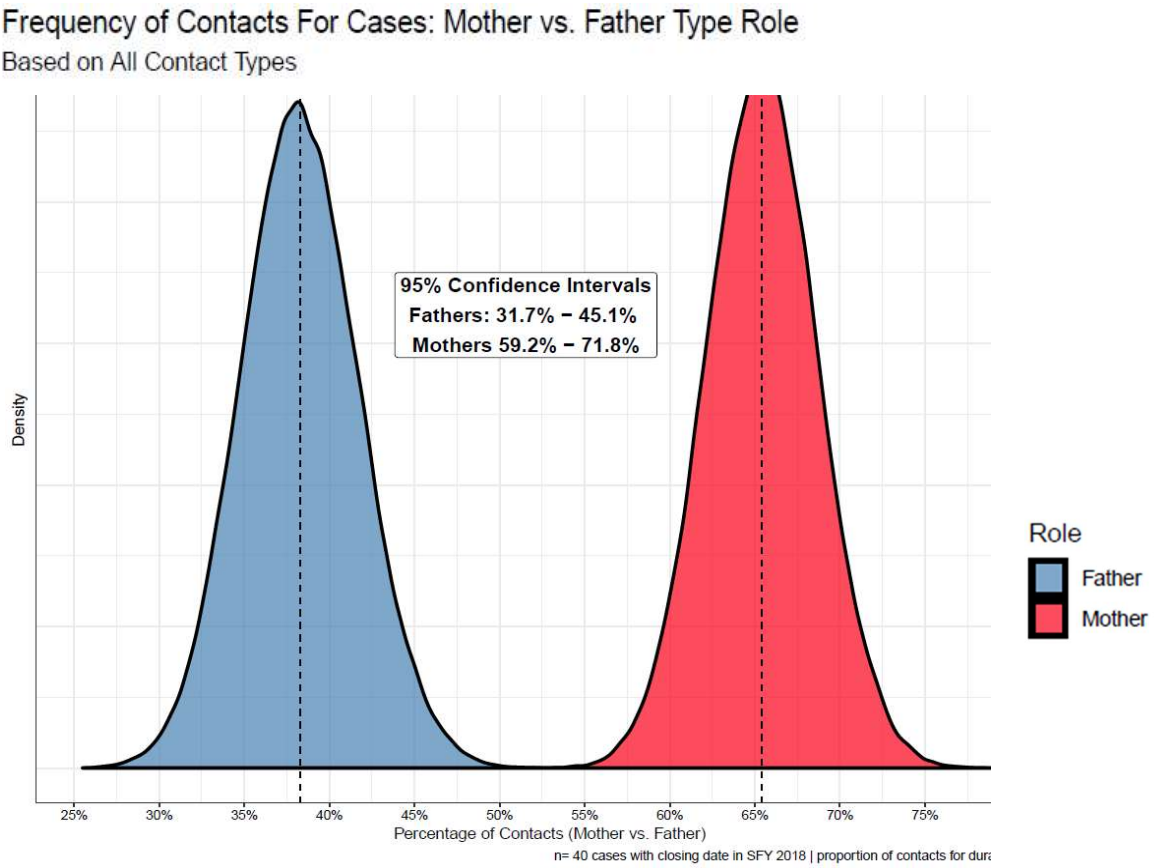


Figure 3.4: Using a randomly selected sample of 40 cases, it was estimated that fathers only received on average 32% to 45% of the contact proportions for parents statewide.

Family Assessment Inclusive Reunification (FAIR) is a system to review and ensure sustained attention with families in an effort to achieve timely permanency. These meetings occur through regular intervals in placement cases starting ten days after removal for child protection and thirty days after removal for juvenile justice cases. The data in figure 3.5 below examines parental attendance at these meetings on a statewide level for both child protective and juvenile justice between State Fiscal Years 2011 through 2018. Data is grouped by the parental attendance makeup depending if one parent, both parents or none of the parents attended. This data further illustrates the overwhelming need to engage parents, particularly fathers in case planning for their families.

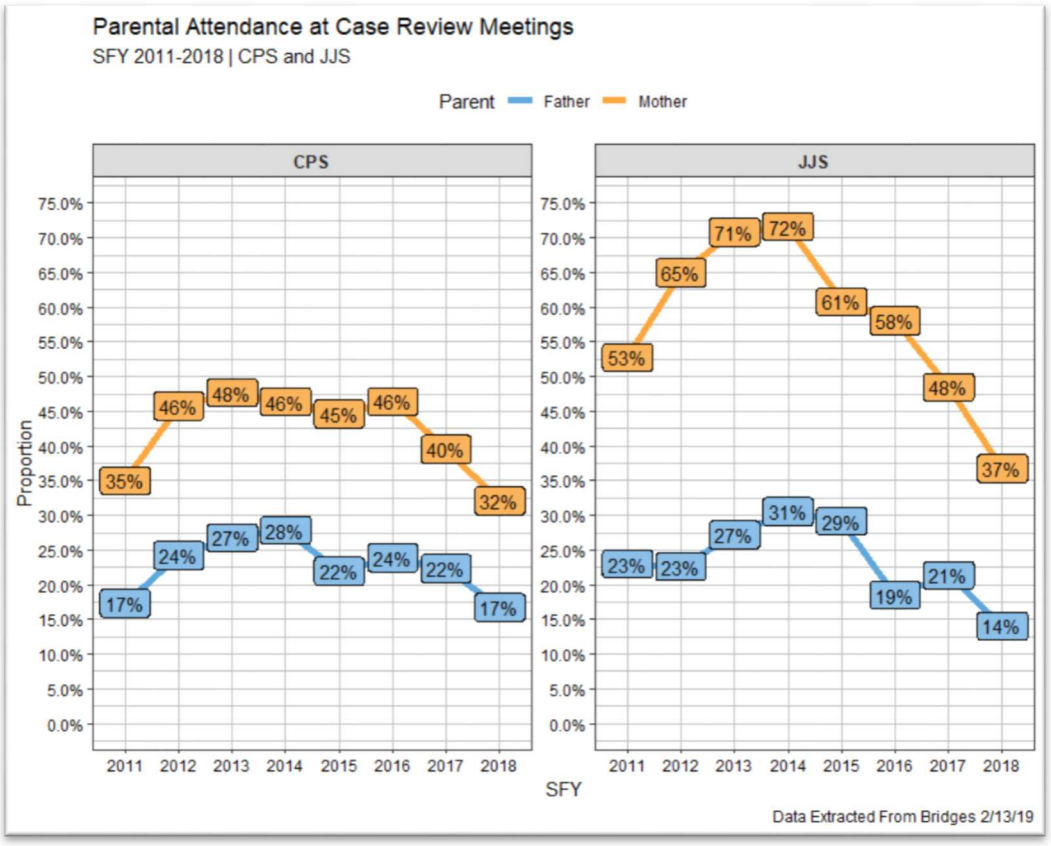


Figure 3.5: There has been an increasing trend statewide for both CPS and JJS, where no parent has attended the case review meeting.

Figure 3.6 explores trends around the proportion of meetings that were attended by mothers and fathers for child protection and juvenile justice separately, for the same period as above.

The Family Assessment Inclusive Reunification data shows a downward trend for both mothers and father attendance in child protection and juvenile justice over the last couple of years.

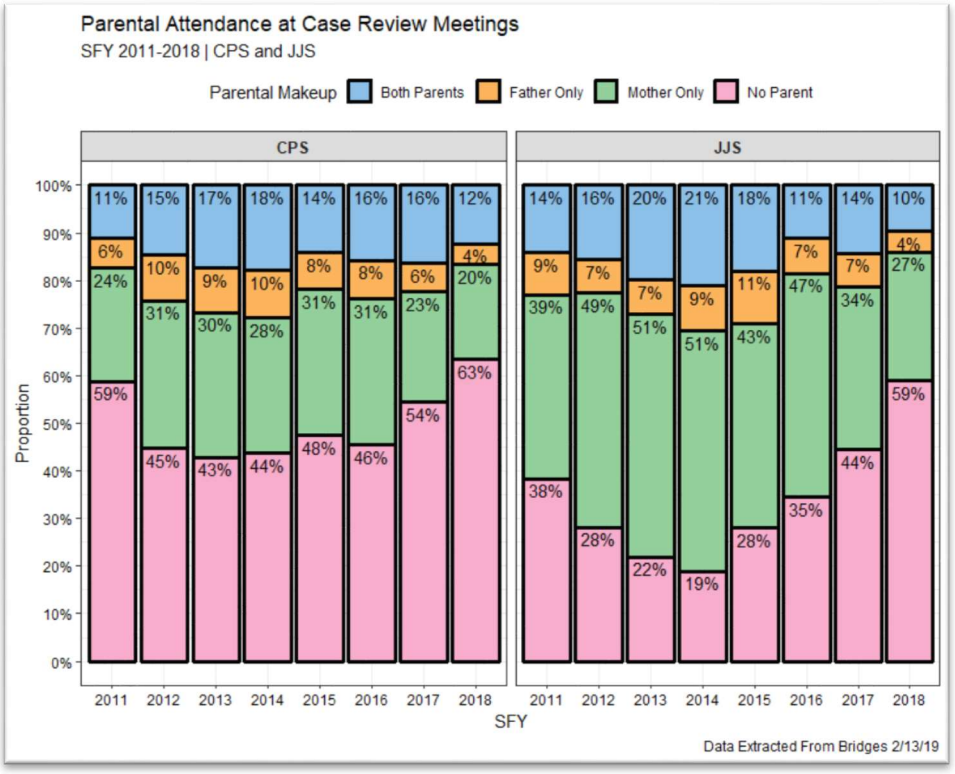


Figure 3.6: Data shows that mothers attend case review meetings at higher rates than fathers. Attendance for fathers has been consistently low across both field practices across a multiyear span

The data from the Case Practice Reviews noted in the above section, in support of Strategy 1, shows fathers had a vastly higher proportion of *area needing improvement*s than the mothers for the same measures. Strategy 2 is the development of a statewide *Father Engagement Action Team,* which would increase attention on identifying and empowering more fathers to participate in case planning for themselves and their child(ren). The *Father Engagement Action Team* piloted in the Laconia District Office in calendar 2012. The district office identified the following benefits for engaging the father's family members:

- Use as a safety resource;
- Obtain health information;

- Maintain or create family connections, (they may not know that they have a relative out there); and
- Locate the absent father.

The Laconia District Office improved their capacity to find biological fathers and the initiative resulted in fathers being more readily identified, located and engaged. The documentation in Bridges regarding biological fathers identified during assessments is shown in Figure 3.7 for the Laconia district office during calendar years 2010-2013.

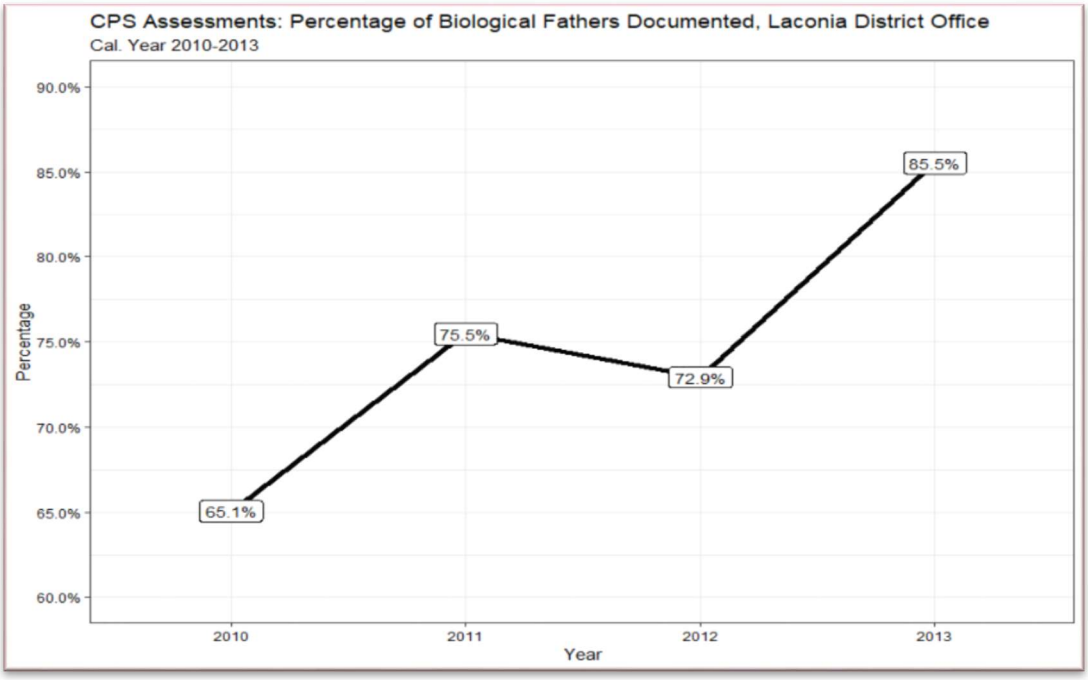


Figure 3.7: A general improvement trend can be seen in Laconia's data around identifying biological fathers.

It is noted that father participation in treatment team meetings showed increasing trends during the Father Engagement Action Team (FEAT) pilot. Additional data is displayed below comparing the attendance rates of fathers for meetings for State Fiscal Years 2011 through 2013 for Laconia and for all the other district offices.

Additionally, reunification increased with fathers, as eleven reunifications out of twenty-one that Laconia achieved in 2012 were with fathers. National statistics show that engagement with fathers can increase timeliness to permanency by twenty-five percent. Two focuses in *Goal 2: Permanency* are concurrent planning and identifying, locating and engaging missing parents, both complimenting the FEAT strategy.

Energy for the program grew and spread into the community, building topics around fatherhood in their parenting programs, and bringing on board additional fathers who were connected with the Family Resource Center . In all, the program was successful in keeping the conversation around fathers going and for showing the value in father engagement. Unfortunately, despite best intentions the pilot ended without being spread statewide due to shifts in Division priorities..

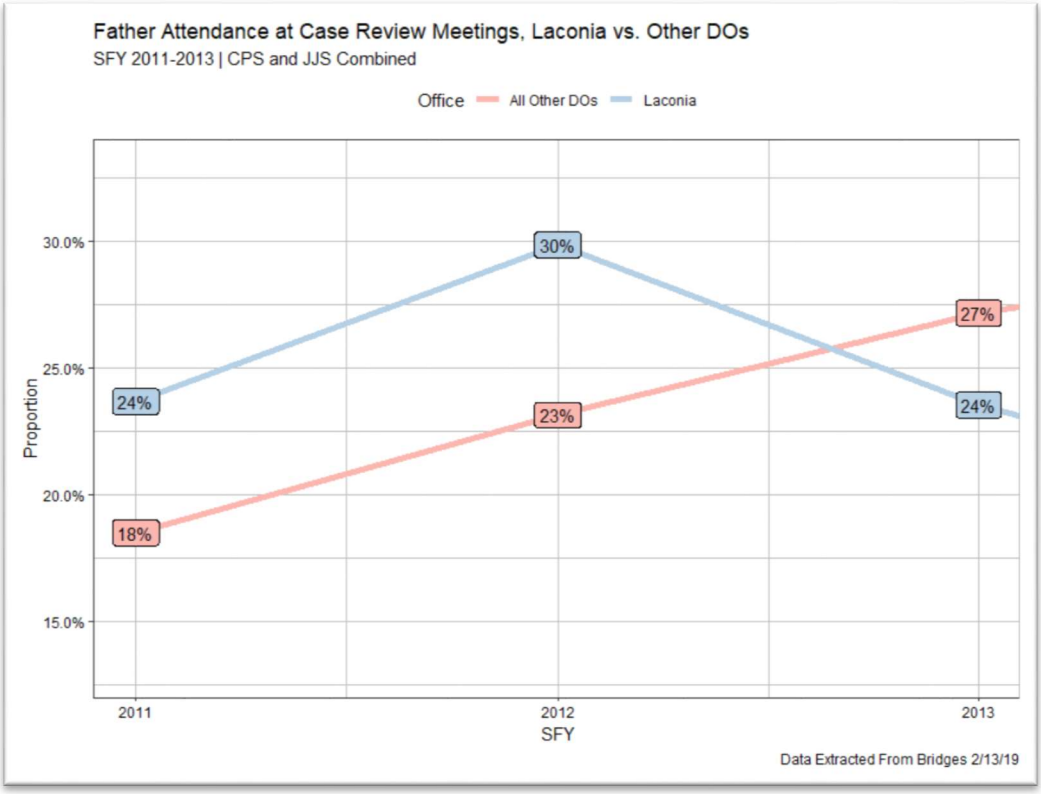


Figure 3.8: Laconia shows a considerable difference in comparison to all the other DOs during state fiscal year's 2011 and 2012, followed by a drop in 2013, which could be explained by the FEAT pilot no longer being a focus in that office

Engagement Strategy 2: (Outcome Items: 2, 3, 6, 8, 9, 10, 11, 12, 13, 15)

DCYF will improve engagement with fathers resulting in an increase in fathers' presence and participation in all case activities, through building staff capacity and increase use of tools to identify, locate and engaging fathers.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 6

THEORY OF CHANGE:

CFSR data for the *period under review* [April 2017-April 2018], Item 15 *Caseworker Visits with Mothers* was rated at fifty-one percent (51%) strengths and *Case Worker Visits with Fathers* was rated at twenty-nine percent (29%) strengths, indicating that lack of engagement with all parents, particularly fathers. This impacts DCYF's ability to assure safety of all children in the home, assess and address the needs of both children and parents, involve and place children with relatives, case plan and achieve timely permanency. The first *Father Engagement Action Team* piloted in Laconia District Office, where staff worked alongside birth fathers to empowered fathers' roles in their children's lives, resulted in a cultural shift within the office. Staff intentionally asked about fathers, sought out fathers input and participation in case planning for their children and families, and this resulted in more children either not coming into state care, or reunifying with fathers and/or being placed with paternal relatives. The enthusiasm for fatherhood spread statewide as this team presented their practice to other DCYF staff, fathers shared their stories during *Better Together with Birth Parent* workshops, during local Parent Partner events, and during state Leadership meetings, which resulted in increased rates of father engagement overall across the state. Although the *Father Engagement Action Team* was a local team in Laconia; DCYF theorizes that this same work can be done on a statewide level and will develop and enact a statewide action team comprised of representatives from each district office, and parent leaders in the Division. These representatives will be a strong champion, and exemplary in their practice within in their office for fatherhood, and who will be able to energize new ideas and motivate their peers to engage fathers in a different way. The practice of increased engagement of fathers positively affect outcomes for families overall.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. Establish a statewide *Father Engagement Action Team (FEAT)*, consisting of members from child protection and juvenile justice from each district office, fathers/parents. a) District Offices will identify staff who champion father engagement to support their offices as peer coaches by participating and providing input on family and father engagement during district office meetings, and utilized as a support to families as needed and capacity allows (i.e. case	Quarter 1 (a-e)	

consultations, Permanency Planning Team (PPT), Family Assessment Inclusive Reunification (FAIR), supervisions, meetings with families, etc.) b) Fathers will be identified by the Parent Partner Program Administrator and team c) A training liaison from the Child Welfare Education Partnership (CWEP) will be included on the team. d) Parent Partner Program Administrator and FEAT co-leads will identify team roles (i.e. agendas, meeting minutes, distribution of meeting materials, facilitation, etc.), expectations for meetings, outcomes for meetings, etc. e) During Leadership meeting, message the mission and goals of the FEAT team, including expectations that FEAT staff will be bringing practice changes back to their offices; and ways that supervisors can use supportive and educational supervision around these practice changes. f) Conduct a regularly scheduled FEAT Team meeting among statewide FEAT staff (documented by meeting minutes). • Support identifying and spreading practices statewide in support of developing a Division culture where fathers are valued and engaged early and ongoing. • Provide qualitative measures of progress with father engagement, which will include participation of birth fathers. • Provide feedback during DCYF leadership meetings.	Quarter 2	
2. Utilize the *Father Engagement Action Team* curriculum to educate child protective and juvenile justice staff around how to involve fathers actively. a) Incorporate *Father Engagement Action Team* concepts in core academy (which all staff can participate in) to emphasize the importance of making early efforts to locate and engage missing fathers, as well as the ongoing efforts to engage once a case has been opened. b) *Father Engagement Action Team* curriculum will be added to the new worker mentoring log to provide direct practical experience and an active transfer of learning experience. c) Supervisors will impart the importance of sustained efforts to locate and include all fathers are being made.	Quarter 4	

3.	Improve the practice of engaging fathers through: a) Increase participation and documentation of fathers' participation and right to be heard in case planning for his child(ren) through ensuring staff include their names and contact information when making referrals, and through work with treatment, service, and placement providers. b) CPSWs and JPPOs will demonstrate transfer of knowledge (*Goal 2: Permanency Strategy 3*) in documentation both their initial and ongoing attempts to identify and engage the non-custodial or missing father (i.e. SACWIS/CCWIS contact logs, affidavits, court reports). c) Partner with Community and Family Supports Program Specialist to identify ways to incorporate father-specific services within re-design of community home-based service array, which will be addressed within the Child and Family Services Plan (CFSP).	Quarter 4	
4.	With the support of the Department of Health and Human Services, Fatherhood Integration team, develop a Department wide acknowledgement to identify, engage, and provide gender-specific responsive practices. a) Break down silos within the Department to support early identification and engagement of fathers, including expanding the ability for workers to access departmental database information to search for missing fathers b) Increase use of and access to missing parent tools in order to identify, locate, and engage fathers (see *Goal 2: Permanency Strategy 3*). c) Expand the ability for workers to access online tools such as Facebook and Accurint to search for absent parents.	Quarter 6	
5.	Progress on this Strategy will be measured as determined through the approved measurement plan through the Case Practice Review as well as through regularly run reports.	Quarter 6	

Progress to Date

In December 2018, the Department of Health and Human Services developed a Fatherhood Integration Team, which is comprised of members from various divisions within the department, including DCYF, and strives to enhance collaboration and partnerships in an effort to support greater access to resources and supports for fathers served by the department.

To begin to address training needs around parent engagement and challenging conversations the DCYF Annual Conference planning committee approved a number of related workshops. DCYF held their annual state conference in April 2019 which highlighted various workshops relevant to New Hampshire's need to improve engagement including: *Preparing for and Managing Difficult Interactions* (138 registrants), *Basic De-escalation Skills* (fifty-four registrants), *Domestic Abusers as Fathers and How to Engage Them* (113 registrants), *Restorative Practices* (25 registrants) and *Nurturing Fathers* (thirty-one registrants).

The Parent Partner Program organized and facilitated fourteen *Better Together Workshops* bringing together fathers, mothers, DCYF staff, and community partners to participate in an intensive two- day workshop. The goals of these workshops is to leverage the parents as training partners by having them share their experiences and be a voice for families helping train DCYF staff and community partners in the art of engaging families in Child Welfare. "*Drawing On Father's Strength*" is a module within these workshops. This module engages participants in a group activity aimed at identifying the barriers for father engagement, and identifying tools and strategies to support increasing the positive engagement of fathers. Over eighty newly hired DCYF staff engaged in this learning experience, gaining knowledge and skills on how to identity, engage, and positively work with fathers.

With the further development of programs lead by birth parents including *Better Together with Birth Parent*s, and *Strength to Succeed*, there has been a greater emphasis on empowering fathers to become stronger leaders within the Division as well. DCYF hopes to bring a strong father onboard to co-lead the statewide *Father Engagement Action Team*.

In January, representatives from management and the field came to consensus on the need to shift practice toward a family centered preventative approach to working with families involved with juvenile justice. From this, policy development has begun, and intensive practice conversations have been held at all levels of the agency to ensure consensus around common definitios and clarity around expectations for field work. Activities to support practice shifts including practice discussions and training revision will be forthcoming.

Goal #4: (Workforce Development)

CFSR OUTCOMES: SAFETY 1-2; PERMANENCY 1-2; WELL-BEING 1,3

Systemic Factors: Staff and Provider Training; Statewide Information Systems

Improve safety, permanency and well-being outcomes for children and families through investment in staff professional development.

In the CFSR conducted in April 2018, evaluating families served by DCYF during the *period under review*, [April 2017-April 2018], New Hampshire received an overall rating of *area needing improvement* in the systemic factor staff and provider training (*Ongoing Staff Training*). At the time, there were different annual training requirements for Child Protective Service Workers and Juvenile Probation and Parole Officers within the Division, and at the time of the 2018 CFSR, DCYF, through the former training contractor, was unable to track compliance accurately with the staff annual training standards. Additionally, it was determined that there was not relevant training available for supervisors.

In the CFSR conducted in April 2018, evaluating families served by DCYF during the *period under review*, [April 2017-April 2018], New Hampshire also received an overall rating of *area needing improvement* for the Systemic Factor: *Statewide Information System* (Bridges), based on information from the statewide assessment and stakeholder interviews. It was determined that there is no oversight of the accuracy of demographic data entered in the statewide information system. Stakeholder interviews indicated staff do not rely on Bridges for accurate locations of children in foster care, and instead maintain systems outside of Bridges to know where children in placement are located, and that data entry around placement is not timely.

ROOT CAUSE PROCESS

New Hampshire researched and analyzed qualitative and quantitative data to determine the root cause of the Division's struggle to ensure the safety, permanency and well-being of children are maintained consistently and ongoing through annual training requirement of all staff and appropriate and accurate documentation of case information. Data staff conducted root cause analysis and a deep exploration into the quantitative results and the qualitative narratives for each Item of the On-Site Review Instrument to identify themes in practice that led to the *area needing improvement* ratings. From these themes, problem statements were developed. Subsequently, focus groups were held with Training Partnership Staff, DCYF Leadership and Juvenile Justice Policy Workgroup to process "the Five Why's" of the following problem statements:

- Accurate client demographic data including home visits, placement data, separation of siblings, and case plan goals are not consistently entered timely in Bridges. Data entered into Bridges is not consistently being checked for accuracy.

- Ongoing supervisor and staff training does not meet current trends and specialized needs of families

However, it should be noted that through the root cause process in regard to other outcome Items several problem statements found the cause to be associated with the lack of access to training or the need for more specialized training. Possible root causes identified through the focus groups were further evaluated. Data from the statewide automated child welfare information system (SACWIS) known as Bridges was queried to analyze supervisor and staff training offered and attended for both child protection and juvenile justice, timeliness of service authorization entry and timeliness of case contact entry. Policy and Medicaid rules along with exit interviews from 2016 through 2018 of staff who left a position for another position either in the DCYF or outside the Division and Stay Surveys results were all analyzed.

The following root causes emerged as contributing factors for New Hampshire's low performance on the systemic factors for workforce development and information systems as well as they negatively influenced the performance on the permanency outcomes are as follows:

- Engagement with families, particularly staff comfort and skill with facilitating challenging conversations (i.e. child removal, safety planning, identifying and engaging the absent or non-custodial parent, engaging non-petitioned siblings, concurrent planning, juvenile justice role and responsibility within the context of the entire family system, etc.);
- Lack of available experienced mentors and supervisory support;
- Staff being unable to complete required training before taking on primary assignments and entering data in Bridges;
- Too many locations to enter the same data in Bridges; and
- A lack of an effective system to remind staff of tasks that need to be completed

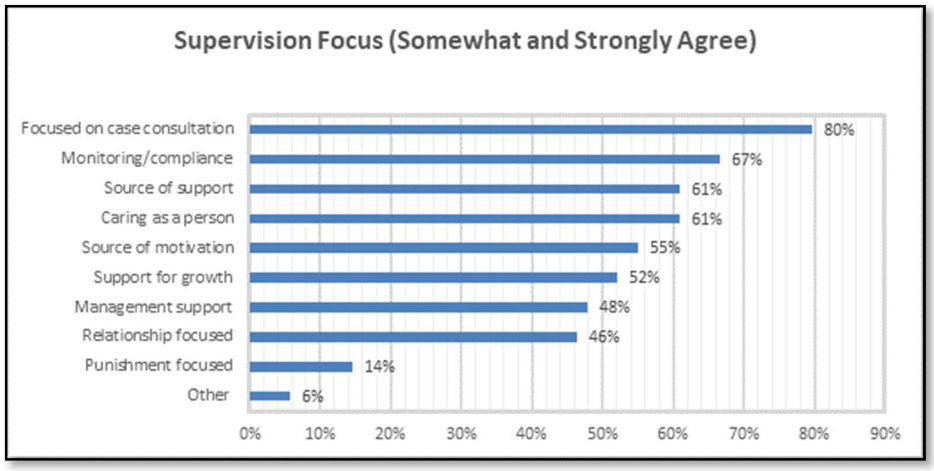
These drove the creation of the strategies to improve performance in relation to the following:

- Creating and providing new Supervisory Core Academy
- Enhancing ongoing and specialized training for all staff
- Development and implementation of a data quality review system during Case Practice Reviews

SUPERVISORY TRAINING DATA ANALYSIS

Through various focus groups it was determined the root cause preventing positive outcomes for children was attributed to the lack of ongoing supervisor and staff training. The first Strategy below focuses on the importance of creating and providing an enhanced ongoing Supervisory Core Academy for new supervisors, covering among other things, New Hampshire Supervisory Standards; coaching; and hiring, and progressive discipline.

In 2018, there were 70 juvenile justice and child protective supervisors in DCYF statewide. In the last two years, at least fourteen of those supervisors are new. In 2016 and 2017, the Department of Health of Human Services, Bureau of Organization Development and Training Services (ODTS) held a new supervisor training that was not child welfare specific. There were fifteen child protective and juvenile justice participants. Also in 2016, new supervisor five-day training was held with a child welfare focus with twenty-three participants from DCYF. In 2018, there were no participants from DCYF in ODTS new supervisor training and there was no specific child welfare new supervisor training held.



Data Source: Stay Survey, July 2018

Figure 4.2: 80% of supervisions focus on case consultation and 67% on monitoring/compliance

Figure 4.2 shows data gathered and analyzed from the DCYF *Stay Survey* conducted in July 2018, in partnership with Melissa Wells, an Associate Professor of Social Work for the University Partnership Child Welfare Program Coordinator with the University of New Hampshire. The survey had 69 respondents and overwhelmingly the data indicates supervisions are covering case specific consultation and compliance with case requirements. This chart aligns with feedback reported from the field about what they are experiencing. Staff report being concerned as to whether they are meeting all of the requirements of their work, given their high workloads. As a result, they feel they need supervisory support and oversight with compliance and monitoring of required tasks.

Exit Interviews are a voluntary process conducted when an employee leaves DCYF employment. A sampling of Exit Interviews was queried from June 2016 through December 2018, totaling 56, with each survey containing eighteen questions. Regarding supervision, some common themes emerged including the need for supervisors to be more available to staff, balance with application of the New Hampshire Supervisory Standards, (administrative, educational and supportive) and minimizing interruptions during scheduled supervision. Further, it was suggested that supervision time be used more efficiently to create individualized plans to support getting the work done and perform job related tasks while meeting in support of moving the process along quicker (i.e. sending the approvals for a service when discussing the need for a service). Strategy 1 focuses on the development of Supervisor Core Academy for new supervisors with the ability for seasoned supervisors to refresh their skills as needed. Supervisor Core

Academy will support supervisors in improving their ability to provide supportive, administrative, reflective, and educational supervision to their staff in order to sustain supervisory competencies. In collaboration with the Child Welfare Education Partnership (CWEP), all Supervisor Core Academy modules will be implemented by the end of 2019.

Workforce Development Strategy 1: (Outcome Items 1 through 18, 26, 27)

DCYF and training partners will build a Supervisory Core Academy *to improve their ability to provide supportive, administrative, reflective, and educational supervision to their staff. The training will build supervisory capacity, so that supervisors enhance the skill of their staff, which will result in better outcomes and an increase in consistency in standards for families.*

PROJECTED START DATE: QUARTER 1
PROJECTED COMPLETION DATE: QUARTER 4

THEORY OF CHANGE:

CFSR data for the *period under review* [April 2017-April 2018], found there are many new supervisors in child protection and there is no relevant training specific to supervising in child welfare. DCYF has not provided formal supervisory training specific to the duties of child welfare professionals since 2016, however the Department of Health and Human Services has provided a five module, *New Supervisor Training Series* which focuses on foundations, communication, conflict management, hiring and performance management. Supervisors have different skill levels around managing and supervising workers in all areas of practice, with some supervisors having no prior experience in the area they currently supervise. New supervisor core training will be implemented by the end of 2019 and available to all supervisors who have not yet participated in DCYF Supervisor Training. Modules will align with New Hampshire Supervisory Standards for educational, supportive, administrative, and reflective supervision. There will be a focus on teaching supervisors how to coach and model with their employees using the UC Davis Coaching Model[7]. Coaching, as noted in other areas of the PIP, will result in supervisors more effectively and consistently modeling skills to staff, who will transfer the skills to meet the needs of the

[7] *https://humanservices.ucdavis.edu/file/implementing-coaching-child-welfare-practice*

families supported by DCYF. Further families will have a more consistent experience in child welfare regardless from which district office they are served.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. APHSA will work with CWEP, staff and supervisors to create a curriculum to deliver to supervisors beginning April 2019 and running annually as needed. a) Focus Groups will be held with supervisors to identify specific training needs for supervisors; b) DCYF and CWEP will meet with APHSA consultant to create: • Content For The Curriculum That Incorporates: New Hampshire Supervisory Standards, Coaching, Hiring And Progressive Discipline, Concepts From National Child Welfare Workforce Institute On Supervision And Management; • Review And Finalize Content Of Modules Through The Child Welfare Systems Transformation Workforce Development Group; and • Review ODTS Curriculum for Content to Determine What to Include In Modules. c) Roll training out to all new supervisors who have not yet been though supervisory training within the last three years, or as determined by field administrators starting in April 2019. • Training module one (Better Me + Better You = Better Us) will roll out to begin in April 2019 for supervisory cohort 1 and cohort 2 • Training module four (Staff Performance Measures and HR Processes) will roll out to begin in May 2019 for supervisory cohort 1 and cohort 2 • Training module three (Coaching) will roll out to begin in June 2019 for supervisory cohort 1 and cohort 2 ➢ Training module two (Parallel Processes of Family and Staff Engagement) and five (Better Us and Professional Development) will roll out by December 2019. ➢ As new supervisors are hired, they will enroll in future cohorts that will be offered as needed.	Quarter 1	
2. CWEP will explore their capacity to evaluate the coaching model, to determine efficacy to the fidelity of coaching practice. If	Quarter 4	

assistance is needed, CWEP will explore working with UC Davis to develop an evaluation component.		

ENHANCEMENT OF ONGOING TRAINING DATA ANALYSIS

Strengthening staff retention and increasing staff positions will reduce high workload and decrease employee turnover. Through various focus groups, it was identified that training did not meet current trends and specialized needs of families in order to provide positive safety, permanency and well-being outcomes. Further, there were concerns about staff being assigned primary workloads before they were sufficiently trained due to the volume of work and the limited staff. One of the questions from the exit interview is, 'What did you find was most and least satisfying about your job?' While there were positive aspects such as the success of 'reuniting families' and the 'support of the team', there were other topics that proved to be quite concerning. Among these was the issue of high turnover rates, resulting in heavy workloads for remaining workers.

In review of the qualitative data from the exit interviews, one question asks 'Do you believe you were supported in accessing training opportunities beyond your initial training?' Although many respondents reported their supervisors supported them, an overwhelming majority indicated they simply had no time to attend due to heavy workloads. Many also noted that there were some specialized trainings offered but those trainings as well as more advanced trainings needed to be offered more often. Others felt the classes that were advertised on the training website had little relevance to their job function or they did not have interest in the topic of the training. There are more training opportunities offered through other state agencies, or within the community, however these training opportunities are often not well communicated. Figure 4.4 shows the themes in the qualitative narrative for this question.

Sufficient and specialized training is critical in child welfare. In Strategy 2, DCYF and the Child Welfare Education Partnership (CWEP) will develop and create access to ongoing professional development and

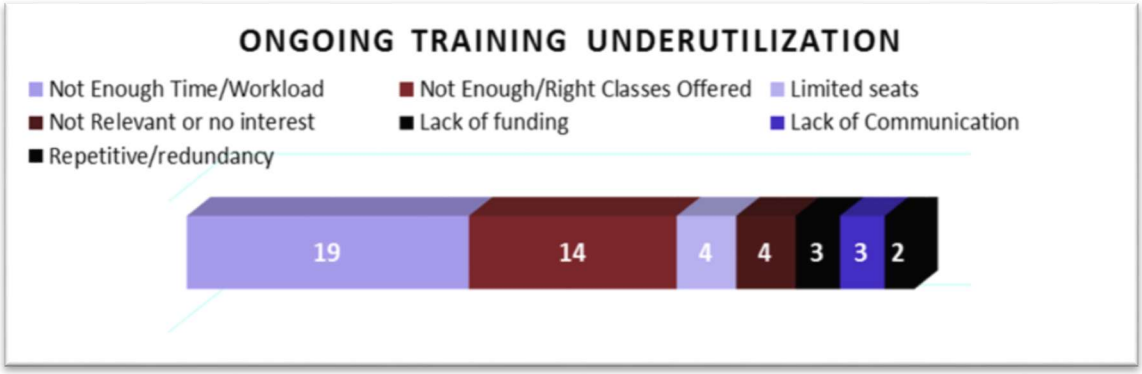


Figure 4.4

Data Source: Exit Interviews

track ongoing training for their regions, provide reports, and meet with each District Office on a regular basis to ensure training needs are being met.

Workforce Development Strategy 2: (Outcome Items 1 through 18, 26, 27)

DCYF and training partners will enhance ongoing training and staff retention of skills for CPSW, JPPOs and Supervisors by building opportunities for staff to participate in relevant training based on their needs, in order to sustain core academy competencies and advanced skill development.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 8

THEORY OF CHANGE:

During the *period under review* [April 2017-April 2018], CFSR data indicated that DCYF staff felt that there was insufficient ongoing training that addresses the skills and knowledge base needed to carry out their duties. It was found that DCYF was unable to track compliance with ongoing training requirements. Instructor coaches will conduct informal assessments of staff in their assigned offices in order to identify training needs. This will support the development of new trainings or if appropriate, the instructor coaches will support staff to locate and access the relevant training requested. DCYF and the Child Welfare Education Partnership will promote opportunities for relevant ongoing training throughout the year for all staff. In addition, DCYF will update policy in an effort to ensure equality in standards for field staff, as well as inform all staff of annual training requirements. Because of these activities, staff will participate in relevant trainings which will support them in doing their jobs more efficiently, and these transferable skills will improve interactions and relationships with families overall.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. In collaboration with stakeholders and providers, DCYF and CWEP will identify training needs and ensure opportunities for ongoing training for all staff, which includes topics relevant to their job, and communicate these opportunities to staff. (such as: workshops and conferences, specialty trainings, access to courses through DHHS training partners: ODTS and BET; Ongoing Caregiver Training offerings, and professional development: NASW, University Partners) 2. Specialized/Advanced Topics shall include (but are not limited to): a) Safety Planning Training b) Concurrent Planning	Ongoing/ Quarter 8	

	c) Engagement Training		
3.	A combination of Field Administrators, Professional Development task force members and supervisors will attend select Core Academy classes as needed to help identify refresher trainings.	Quarter 2	
4.	CWEP instructor coaches will track ongoing training for their regions, provide reports and meet with District Office supervisors and staff to assess their ongoing training needs, compliance with ongoing training and requirements during regularly scheduled visits to offices bimonthly. This information will also be compiled statewide.	Quarter 2	
5.	As needs are identified, CWEP instructor coaches will support staff in locating an appropriate training to meet those identified needs whether provided directly by DCYF, or providing access to those training opportunities.	Quarter 2	
6.	Revise DCYF Professional Development Policy to update current annual training requirements for all staff and communicate changes to ensure staff are aware of their annual training requirements.	Quarter 1	

DATA ENTRY TIMEFRAMES ANALYSIS

There were multiple concerns around the timeliness and relevance of data entered into the New Hampshire Statewide Automated Child Welfare Information System known as Bridges, particularly around service authorizations for out of home placement.

Root cause analysis showed the challenges with the accuracy and timeliness of data entry was attributed to workforce shortages, staff inadequately trained before being assigned case responsibilities and insufficient training of the mentors assigned to new staff. Strategy 3 will focus on the development and implementation of a data quality review tool utilized during Case Practice Reviews, which will verify the accuracy of data entered into the SACWIS system, and when discrepancies are found, developing a plan with District Office Staff to correct the inaccuracies.

Workforce Development Strategy 3 (Outcome Items 1 through 19)

UTILIZE A CQI PROCESS TO VERIFY AND IMPROVE DATA INTEGRITY THROUGH EVALUATION DURING QUALITY ASSURANCE REVIEWS.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 4

THEORY OF CHANGE:

During the *period under review* [April 2017-April 2018], CFSR data indicated there was not consistent oversight of the accuracy of data entered into the SACWIS system. Some staff indicated they could not rely on the system resulting in staff maintaining tracking systems outside SACWIS to know where children in placement were located. In addition, the entry of placement data was not timely. Through further exploration of this issue with stakeholder focus groups, it was theorized that due to workforce capacity issues, staff are being assigned primary workloads prior to completing their training, and that current classroom training does not teach staff where and how to document information in the SACWIS system. It is reasonable to assume this is covered however in field training with their mentor or supervisor. It is more likely that due to workforce capactity issues staff have a high volume of work, and are prioritizing field tasks over documentation. As identified in *Goal One: Safety, Strategy 2,* over the next two years, NH will expand the number of CPSWs and Supervisors to make up the workforce based on allowances in NH Senate Bill 6. Root cause also identified that NH does not have an effective way to monitor data integrity. Through increased staffing and a quality assurance system to monitor data integrity, data entry will become more consistent and timely and will improve all staff's ability to locate critical information when it is needed. It will also result in more accurate data, which will strengthen New Hampshire's overall reporting ability, quality assurance and quality improvement system.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE

1.	Incorporate into Case Practice Review Interview Guide questions that evaluates accurate demographic information in the SACWIS/CCWIS system: a) Accurate child date of birth; b) Accurate demographic information for children and parents; c) Accurate placement data (specifically placement changes and reunifications)	Quarter 1	
2.	Evaluate and review data findings gathered from these quality assurance processes with Leadership and/or during Case Practice Review Exit Conferences.	Quarter 4	
3.	Based on review findings, a) Identify barriers to maintaining accurate and timely documentation; and b) Take action to improve documentation of demographic information that is supported at all levels of administration.	Quarter 4	

Progress to Date

In support of creating a Supervisor Core Academy, DCYF and the Child Welfare Education Partnership worked alongside staff from APHSA during the summer of 2018. Focus groups were conducted with supervisors; content for the curriculum was created including incorporating New Hampshire Supervisory Standards. In January and February 2019, the DCYF Workforce Development Committee met to review and approve the content of the modules and to review and incorporate content from other DHHS supervisory training series. Three modules of Supervisor Core Academy have been successfully held between April and June 2019.

In April 2019, DCYF held their state conference which highlighted various topics relevant to New Hampshire's need to provide all staff access to relevant training specific to their job duties. Among the workshops included were: *Solving Problems Collaboratively and Proactively*; *Safety Culture*; *Time Management in DCYF Practice*, *Preparing for and Managing Difficult Interactions*, *Basic De-escalation Skills*, *Domestic Abusers as Fathers and How to Engage Them*, *Restorative Practices*; *Current Drug Trends*; *Weapons ID and Safety While on the Job*; *Gang Awareness*; and *Nurturing Fathers*. Additionally there were several workshops on self-care, and DCYF's vision for the work in upcoming years. In total, there were 467 individuals registered consisting of over 200 DCYF staff, and external stakeholders.

Goal # 5: (Service Array)

CFSR OUTCOMES: SAFETY 1-2; PERMANENCY 1-2; WELL-BEING 1, 3

Systemic Factors: Service Array; FP/AP Licensing, Recruitment and Retention

Evaluate and Expand the Accessibility and Use of Safety and Permanency Services.

For cases reviewed during the *period under review*, [April 2017 to April 2018], New Hampshire received an *area needing improvement* in Well-being Outcomes 1, 2 and 3 (Items 12-18) and in the Systemic Factor: *Service Array and Resource Development* (Items 29, 30). It was determined that even when needs and services are appropriately identified, children and families are often unable to access those services due to a diminished service array.

For cases reviewed during the *period under review*, [April 2017 to April 2018], New Hampshire received an overall rating of *area needing improvement* in the systemic factors related to foster and adoptive parent training (Item 28) and foster and adoptive parenting licensing, recruitment and retention (Items 33-36).

It was also identified an *area needing improvement* in New Hampshire, both child protection and juvenile justice, was providing safety services (Item 2) specifically to address parental substance abuse and domestic violence. In 2018, five district offices had Master Licensed Drug and Alcohol Counselors (MLADC) and each district office is connected with a domestic violence crisis center, and a Family Violence Prevention Specialist (FVPS).

ROOT CAUSE PROCESS

New Hampshire researched and analyzed qualitative and quantitative data to determine the root cause of the agency's struggle to provide appropriate and timely services to families that are individualized their needs; have effective foster care retention and recruitment system; and ensure equal and efficient service provision statewide. Data staff started root cause analysis and a deep exploration into the quantitative results and the qualitative narratives for each Item of the On-Site Review Instrument to identify themes in practice that led to the *area needing improvement* ratings. From these themes, problem statements were developed. Subsequently, focus groups were held with Family Service Child Protective Service Workers, Adolescent Workers, Foster Parents, Recruitment Workers, CASA, Birth Parent Attorneys, Training Partnership Staff and Child Protective Permanency Workers to process "the Five Why's" of the following problem statements:

- There is a lack in available foster and adoptive families statewide;
- Parents needs are not consistently assessed, providing service to parents and all caregivers for those needs, and responding to their requests for services;
- The services referred do not adequately match the need to mitigate risk and safety;

- Children/Youth's needs are not assessed consistently and individualized services to meet those needs are not consistently provided.
- DCYF doesn't have an effective system for recruitment of placement providers (foster and adoptive).

Further, data from the statewide automated child welfare information system (SACWIS) known as Bridges was queried to analyze placement caseloads, foster home availability and location, contact logs, NHIA household member roles; relative homes and group/residential placements. Specific attention focused on differences between district offices based on many factors including but not limited to: workload; population demographics; social deterrents; available services; and staffing. Further, agency/provider provided data were reviewed; youth surveys and Random Moment Sampling results were analyzed. The Adequacy and Enhancement Assessment (2018), trainings offered versus attended, policy and Medicaid rules were all researched.

The following root causes emerged as contributing factors for New Hampshire's low performance on the well-being outcomes and systemic factors for foster care and service array are as follows:

- Services are not available in all communities;
- Lack of services to meet child's higher needs;
- Referral process is different for each agency/provider;
- Funding restraints;
- Lack of training, communication and support for foster parents and no specialized foster parent recruitment

These drove the creation of the strategies to improve performance in relation to the following:

- Enhancing risk and safety related services;;
- Individualization of services;
- Provision of prevention services; and
- Increasing available placement resources.

INDIVIDUALIZED SERVICE AND COMMUNITY HOME BASED SERVICES DATA ANALYSIS

DCYF has a number of community home-based service providers. Data suggests that these providers do not provide the same quality of service, even within the same service category. For example, some providers exceed the minimum requirements of a service per Medicaid rules. Additionally, data currently collected from these providers self-evaluates their effectiveness to deliver services. DCYF community-

based service providers can also assist improving services through receiving and providing their data more efficiently.

In conjunction with the providers, DCYF created a unified referral form in the spring of 2019. Previously, the providers each had their own referral form that DCYF staff had to complete in order to refer a family for the same level/type of service. As one of the concerns of the CFSR was wait times for services, this will allow DCYF to complete one referral form and submit it to multiple agencies at one time rather than waiting for a response from one provider before completing a referral form for a different provider as was the previous case, streamlining the referral process.

New Hampshire had 748 organizations providing twenty-four services from 2014 through 2017. These services are not distributed uniformly throughout the state. DCYF is using this data to identify gaps in service location and type, to be used when contracting service providers in the future. Service providers have historically reported client outcomes to DCYF. Outcomes that are determined less by the provider and more evidence based can be developed.

The Bureau of Community, Family, and Program Support is developing a system to refine provider kept data, with a completion goal of the summer of 2019. Strategy 1 is to collaborate with paid service providers to evaluate shared data to better understand gaps in services and improve individualized services for families.

Service Array Strategy 1: (Outcome Items 2, 3, 4, 6, 7, 9, 11, 12, 13, 16, 17, 18, 29, 30)

Evaluate and analyze gaps in community home-based providers in order to create consistency among service providers, reduce wait lists for families, and improve individualized service delivery for families, which will result in children remaining in-home, and/or timelier reunification.

PROJECTED START DATE: QUARTER 1
PROJECTED COMPLETION DATE: QUARTER 6

THEORY OF CHANGE:

CFSR data for the *period under review* [April 2017-April 2018], rated Service Array an *area needing improvement* as service availability across the state and individualizing services were both challenges. One current problem with DCYF service array is consistency in the level and quality of services provided to families across different service providers. In some areas, providers deliver a basic level service, where in other areas; providers deliver beyond what is expected for that category of service. Evaluation of the effectiveness of all home-based services is subjective as the providers submit a self-assessment. New Hampshire has not objectively evaluated home-based providers in a number of years. Data points will streamline to evaluate between providers, and with DCYF, and a quality assessment review of community

home-based providers will be re-instituted. DCYF theorizes this will result in providers receiving feedback about their performance, and accessing support from DCYF to make improvements to their programs, which will result in more consistent quality services for New Hampshire families regardless of which provider they are working with. It will also result in better matching services to families based on what they need and will result in shorter more effective services for families, and/or more timely reunification for children in placement.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. Streamline provider and statewide information systems data points that need to be evaluated including obtaining additional information about the population served, services provided, family progress ratings, reasons for termination of services, services that are needed but not available. a. Administration will meet with CPSWs and JPPOs to ensure referral data includes Case ID# and ensure complete forms in order to ensure effective data analysis. b. Create a more effective database to track the effectiveness of home based services on positive outcomes for families. c. Create a uniform reporting mechanism for home based services providers d. Identify query information to pull from CCWIS system to evaluate the effectiveness of services in addition to evaluating qualitative data service providers are reporting. e. Evaluate the effectiveness of services based on data reported by home based services providers and CCWIS.	Quarter 1 Quarter 3 Quarter 2 Quarter 2 Quarter 5/ Ongoing	
2. Developing and utilizing a system to monitor the effectiveness of the service based on the identified needs of the family. a) Re-designing a process for quality assurance provider site reviews to assess and inform providers about program improvement based on the rules. b) Conduct provider site reviews, analyze site review data and communicate findings with providers.	Quarter 2 Quarter 4	
3. Provider Specialist will review data analysis during quarterly meetings with providers to create more consistency across providers who provide the same service; and to make revisions and/or	Quarter 6/ Ongoing	

additions to services delivered and provide technical assistance to support enhancing their skills.		

When families utilize the community services, it has proven to be beneficial; however, DCYF has not been able to provide similar services to families to ensure participation and support is provided to reduce the risk of harm to the family. DCYF initiated a Voluntary Services program in July 2018 to address the needs of families. In this program, families who wanted assistance and were motivated to reduce identified risk factors could be provided any service DCYF authorizes, except out of home placement, before an assessment is completed, and whether or not there was a finding of neglect or abuse. For the State Fiscal Year (SFY) 2019, $1.5 million was provided to fund those voluntary services. Approximately half way through that period, 76 voluntary service cases were opened, with 377 clients attached to those cases. The policy is too new to measure whether offering Voluntary Services has an effect on the number of children, youth, and families that come into DCYF care. Strategy 2 will focus on the continued work of providing voluntary services to families where children are at high risk of harm.

Service Array Strategy 2: (Outcome Items 2, 3, 12, 13, 16, 17, 18, 29, 30)

Services to reduce risk and mitigate danger will be provided to children and families where there is high risk of harm to the child(ren) in order to allow families to stay safely together.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 8

THEORY OF CHANGE:

CFSR data for the *period under review* [April 2017-April 2018], Item 2: *Services To Protect Child(ren) In-Home And Prevent Removal Or Re-Entry Into Foster Care* showed forty-one percent (41%) strengths rating for services to protect children and prevent removal or re-entry. Further, service availability across the state was noted as a challenge during the CFSR. New Hampshire has not had a mechanism to provide families with supportive services to reduce risk absent a finding of abuse or neglect in child protection for many years due to financial and legislative restraints. In July 2018, legislation approved funding to provide short-term supportive services to children at high risk for maltreatment, in support of keeping families safely intact. DCYF theorizes through continued proactive and preventative access to services, more families will be healthy and intact, and it will lead to less maltreatment for families who want assistance and support to reduce the risk factors for maltreatment.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE

1.	The Voluntary Services/Service Array workgroup will continue to oversee the provision of services to families referred for voluntary services through a DCYF abuse or neglect assessment as determined necessary based on an assessment of family needs and under the current operating budget ($1.5 million for state fiscal year 2019-2020). Services include: case management and direct support by the CPSW, referrals for paid services- DCYF service array, and/or referrals for community-based services.	Quarter 4	
2.	The Voluntary Services/Service Array workgroup will evaluate, plan and implement a broader system of voluntary services for high-risk underserved families directly involved with DCYF through an abuse or neglect assessment: a) Provide short term services through an open assessment as long as the service can be provided within 60-day time frame to align with assessment closing policy (i.e. gas cards, transportation, child health support- parenting education, hygiene maintenance tools, etc.); b) Develop and finalize new policy around this practice; c) Evaluate the effectiveness; and d) Make improvements based on evaluation data.	Quarter 4	
3.	In order to sustain voluntary services and serve more families, DCYF will explore options to support the development of community-based voluntary services, which would be provided to families who are referred by DCYF, and their children are at high risk for maltreatment or removal.	Ongoing/ Quarter 8	

SAFETY AND RISK RELATED SERVICES DATA ANALYSIS

The role of imbedded risk and safety related services within the District Offices has been expanded in recent years. The number of Master Licensed Drug and Alcohol Counselors (MLADC), Family Violence Prevention Specialists (FVPS), and Parent Partners have all been increased so that the staff in the field will have them available for consultations, to provide direct supports to individuals, or support them in accessing community resources or treatment.

In SFY 2017, four MLADCs received 488 referrals, and had contact with 285 clients. This increased to 672 referrals and 404 contacts by seven LADCs in SFY2018. It should be noted that not all seven MLADC were employed the entire SFY. Only one out of three sites that participated in the CFSR (2018) had a MLADC at the time, so data in the CFSR may not reflect actual statewide use of this service. In 2019, the number of MLADCs will increase again. With a more universal dispersal of professionals, DCYF will better be able to gather data by District Office and measure usage to ensure they are being used optimally and efficiently. Figure 5.2 shows the data tracked by the seven LADCs once contracted in SFY 2018.

ASSESSMENT REPORTS WITH SUBSTANCE USE CONCERNS		
Reports Involving an Overdose	81	4.6%
Reports With Child(ren) 3 and Under	852	48.35%
Reports of Infants Born Drug Exposed	210	11.92%
TOTAL	1762	

SERVICES PROVIDED	
Declines in TX	49
Declined Not In TX	54
Did not Respond to Outreach	165
Multiple Visits	229
One Visit	129
Phone Consult	46
Total Families Serves by LADC	**672**

Data Source: LDAC Databases, SFY 2018

Figure 5.2 Thirty-eight percent of the assessments with substance use concerns were referred by the CPSW to the MLADC to make contact with a client, while the remaining assessments, CPSWs may have consulted with the MLADC

Although the Family Violence Prevention Coalition does provide referral data, DCYF needs to expand that, to measure actual service usage and outcomes. Further refining this information would allow data to be used by each individual district office specifically to ensure optimal use of the services. Data sharing and analysis between the Family Violence Prevention Coalition and DCYF to improve consultations and referrals for families experiencing violence to help reduce their risk and mitigate danger.

FAMILY·VIOLENCE·PREVENTION·SPECIALIST¤				
¤	SFY·2016¤	SFY·2017¤	SFY·2018¤	TOTAL¤
DCYF·REFERRALS¤	1,100¤	1,026¤	1,320¤	**3,446¤**
DCYF·CONSULTS¤	2,199¤	1,900¤	1,899¤	**5,998¤**

Data·Source:·Coalition·on·Domestic·Violence¶

Data Source: Coalition on Domestic Violence

Figure 5.3 Statewide the number of referrals to FVPS have increased while the number of consultations with staff have decreased

Strength to Succeed is a new program, which utilizes birth parents who have either experienced substance abuse and/or involvement with DCYF due to concerns for abuse or neglect, and trains and certifies them to become recovery coaches. These trained Parent Partners will work within the district offices, and will support parents with substance use disorders with at least one child under the age of ten. They will support the parent by helping them to build a sober network, as well as access treatment services.

The Parent Partner will also provide assistance to relatives who are raising children that came from homes where substances were misused and build a recovery support network. Parent Partners are not yet imbedded within all of the district offices. The partial data for 2018 shows one provider had five Parent Partners with eighty referrals, while the other hired two Parent Partners with thirty-nine referrals. As these two providers are expected to expand their parent partners to ten and four respectively, better data and increased referral rates are expected. Strategy 3 focuses on increasing the use and efficiency of risk and safety related services available in the district offices or within the community. Strategy 3 will compliment Goal One: Safety in improving the utilization of risk and safety related services.

Service Array Strategy 3: (Outcome Items 2, 3, 4, 6, 7, 9, 11, 12, 13, 16, 17, 18, 29, 30)

Improve utilization of risk and safety related services available in the office (Family Violence Prevention Specialist, Parent Partner, and/or Master Licensed Drug and Alcohol Counselors) or as available within their community to improve outcomes for families through less removals of children and repeat referrals of families with substance abuse disorders.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 4

THEORY OF CHANGE:

CFSR data for the *period under review* [April 2017-April 2018], Item 2: *Services To Protect Child(ren) In-Home And Prevent Removal Or Re-Entry Into Foster Care* showed forty-one percent (41%) strengths rating for services to protect children and prevent removal or re-entry. Further, CFSR data found there are significant gaps in available services, even when service needs are identified appropriately. Long wait lists, lack of providers, transportation issues, lack of drug treatment, lack of community mental health centers were among the identified diminished services. A significant amount of families who work with DCYF experience one or more of the following challenges: substance abuse, domestic violence and/or mental health needs. DCYF contracts with family violence prevention centers and licensed drug and alcohol counselors who are dually licensed to support mental health needs as well. Most recently, DCYF has begun contracting with birth parents who are trained and certified as recovery coaches. All of these individuals are imbedded within each of the District Offices. The expansion of availability and improvement of utilization of Master Licensed Drug and Alcohol Counselors, Family Violence Prevention Specialists, and Parent Partners will allow families to access direct services, even if they are on a wait list for a community program. The families will experience improved rates of reunification, reduced repeat intake referrals when family substance abuse or family violence is a factor, and reduced need of removal of children. By increasing the shared data and specific data points, around families who have accessed these services, it will inform practice and provide performance outcomes.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
master licensed drug and alcohol counselors		
1. CPSWs and JPPOs will document consults and referrals in SACWIS/CCWIS contact logs.	Quarter 1	
2. To support capacity, DCYF will increase the number of MLADCs a) New Master Licensed Drug and Alcohol Counselors (MLADC) will be placed in offices where there are no MLADC services, and prioritized based on the size of the district office, where there are substance abuse service deficits in the community. b) Ensure new MLADCs are trained and providing services within their district offices. c) Redefine the MLADC Supervisor role to include a balance of clinical supervision of MLADCs in order to ensure consistency of services provided across the state, assisting to expand the program, as well as maintain a partial caseload.	Quarter 3 Quarter 4 Quarter 1	
3. Market the MLADC program to CPSWs and JPPOs to expand utilization from just substance abuse to dual diagnosed mental health and substance abuse needs.	Quarter 2	
4. Supervisors, CPSWs and JPPOs will increase their competency in working with families with dual diagnosed substance abuse and mental	Quarter 2	

health condition through increased coaching and modelling from MLADCs and practical application.		
5. The MLADC program will expand their data collection process. a) Submit survey to field to identify needs, and where the program is most effective b) Identify what outcomes will be measured c) Data will be shared with offices quarterly relative to the number of assessments received with substance abuse indicators and the number of referrals made to the MLADC. d) Analysis of outcomes will be conducted to inform improvements with referrals, services and outcomes.	Quarter 2 (overall) Quarter 2 Quarter 1 Quarter 1 Quarter 1	
6. District Office without an assigned MLADC will refer families for substance misuse treatment services within the community.	Quarter 1	
7. Quarterly MLADC data will continue to show sustained use of their services within the offices where available. Case practice reviews will show progress of the utilization of appropriate substance use services through the individual Item ratings.	Quarter 4	
STRENGTH TO SUCCEED		
1. Expand and extend implementation of the *Strengths to Succeed Program* that offers peer-to-peer support to parents in recovery, by birth parents trained in the recovery coach model in every District Office.	Quarter 4	
2. Implement the program in all DCYF District Offices by June 2019.	Quarter 4	
3. Provide the following services (per Strength to Succeed model) for families of children ages ten and younger whose parents abuse substances: a) Peer to peer support (home visits with parents to support engagement with DCYF) b) Relative caregivers support (to assist providing recovery informed supports in support of co-raising minor children who have been exposed to substance abuse, supporting education around traumatic behavior, and supporting relatives in maintaining healthy relationships with the child's parent) c) Facilitated access to community treatment and/or recovery supports (supporting parents in getting connected with community-based treatment or recovery supports and ensuring that they attend and stay connected)	Quarter 4	
4. Parent partners will team up with MLADCs and local Better Together teams to coach and model district office staff in taking a more recovery	Quarter 4	

centered approach to working with parents, and beliefs that families can change. a) General or family specific consultation with CPSW and JPPOs b) Consultation with supervisors around dynamics of substance abuse, including identifying areas for practice discussions c) Hold multidisciplinary practice discussions around target areas within substance abuse		
5. Expand program supports from traditional in-home cases, to include assessment families beginning in June 2019 in an effort to prevent placements.	Quarter 4	
6. In order to sustain the program, parent partners will be trained and certified as recovery coaches and once certification is complete, they will bill Medicaid for their services.	Quarter 4	
7. Baseline data is currently being developed, ongoing tracking of the utilization of parent partners through the strength to succeed program will occur quarterly.	Quarter 4	
FAMILY VIOLENCE PREVENTION SPECIALIST		
8. Data will be analyzed and used to inform practices to better serve families experiencing family violence: a) Supervisors when assigning will submit a copy of the assessment and indicator sheet to the Family Violence Prevention Specialist and copy the CPSW/JPPO for follow up. b) CPSWs and JPPOs will document the referrals in SACWIS contact logs.	Quarter 2	
9. Family Violence Prevention agencies will track their referral and consultation data, and share the following data with DCYF: a) The number of referrals, and consults that are made by district office b) How many referrals result in a connection between the Family Violence Prevention Specialist and client c) What additional referrals are being made as a result of the connection between Family Violence Prevention Specialist and client	Quarter 4	

10. DCYF will survey District Office Supervisors to identify strengths and *areas needing improvement* in work between DCYF and Family Violence Prevention agencies.	Quarter 3	
11. Quarterly meetings will occur each year, between the Family Violence Prevention Specialist and their assigned District Office a) Two of those quarterly meetings will include the Family Violence Prevention Specialist supervisor b) Referral data will be discussed during these meetings, including identifying/overcoming gaps in referrals when there has been a primary indicator for domestic violence.	Quarter 4	
12. Data will be shared with offices quarterly relative to the number of assessments received with domestic violence indicators and the number of referrals made to the Family Violence Prevention Specialist.	Quarter 4	

FOSTER CARE ANALYSIS

CFSR data for the *period under review* April 2017-April 2018, identified that foster parents need more support and better communication from DCYF. From the licensing phase through training, initial placement, and ongoing placement, foster families have expressed a feeling of being unsupported. Case contact information documented in Bridges supports that of all contacts in foster care cases, only twelve percent (12%) occur with foster parents. Figure 5.4 differentiates the contact types with foster parents. Foster parents receive primarily email and telephone correspondence (approximately 57%) compared to face-to-face meetings (approximately 33%).

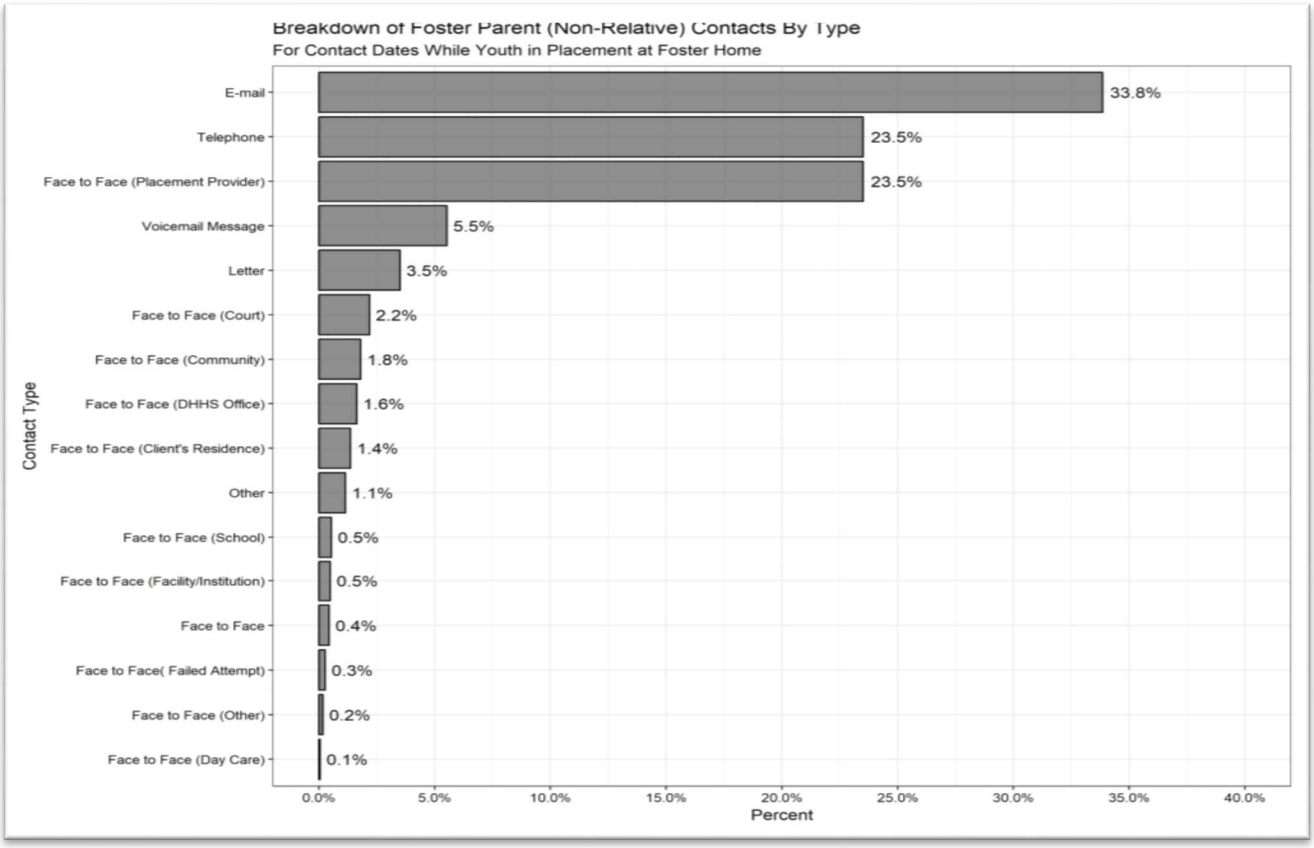
Data Source: NH Bridges

Figure 5.4: Of the twelve percent of contacts with foster parents, emails are the most prevalent type of contact

Strategy 4 will focus on implementing a centralized licensing unit, which will streamline and reduce the length of time it takes to be licensed and accept a placement. Additionally, it will re-design the role of the resource worker allowing them to provide case management to more effectively support foster parents with more timely communication and support, placement, training, and licensing needs.

New Hampshire has 827 licensed Foster Homes as of March 1, 2019, of all types. If the Resource Workers are able to focus on the licensed foster homes in the area and provide one on one support, it is expected that foster parents will feel appreciated and more enthusiastic about fostering. That along with improved and specialized training will lead to the natural recruitment of others to foster children.

Service Array Strategy 4: (Outcome Items: 4-11, 12, 13, 16, 17, 18, 28, 29, 30, 33, 34, 35, 36)



Redesign and implement the central Home Study Unit and the role of the resource worker, which will lead to improved relationships with foster, adoptive and relative caregivers and improve available placement resources for children and youth.

PROJECTED START DATE: QUARTER 1

PROJECTED COMPLETION DATE: QUARTER 4

THEORY OF CHANGE:

CFSR data for the *period under review* April 2017-April 2018, show foster and adoptive parent licensing, recruitment and retention as an overall *area needing improvement*. The requirements for criminal background checks were not consistent between foster and relative homes, problems with retention due to lack of support for foster parents, delays in completing and approving ICPC home studies, as well as access to training to prepare foster families for the children placed in their homes were all areas that needed to be addressed. Through re-designing the central Home Study Unit, which designated staff to support new foster parents with the primary tasks associated with licensure, before assigning a home study practitioner, the time from primary tasks to completion of licensing will reduce. By re-designing the role of the resource worker to become the case manager for their foster families, the retention rates will improve, as families will receive increased communication and supportive relationships with their Resource Workers. Additionally, foster parents will feel more prepared as their Resource Workers will connect them with relevant trainings based on their placement needs. By focusing on retention and relationship building with current foster parents, it will help increase the number of quality foster families, as foster parents are one of DCYF's biggest supporters in recruiting new families.

KEY ACTIONS:	PROJECTED COMPLETION DATE	COMPLETION DATE
1. DCYF will streamline, centralize, and standardize the licensing and unlicensed placement processes in order to ensure standards are applied equally and ensure more timely licensures.	Quarter 4 (Overall)	
a) DCYF will streamline and centralize the inquiry and licensing process for all foster, adoptive, and ICPC homes through investments in the State Office to improve efficiency and timeliness, accessibility, and customer-service orientation.	Quarter 1	
• Expand the role and responsibilities of the State Office Central Inquiry Unit to provide seamless, consistent support across the licensing process to inquiring families	Quarter 1	
• Expand the State Office's capacity to conduct home studies efficiently through:		
➢ Increasing staffing for the Division's in-state centralized Home Study Unit from 4.5 to 8.5 practitioners to complete home study interviews and written home studies within a two-month timeframe from application acceptance date to completion.	Quarter 1	
➢ Creating a centralized ICPC Home Study Unit to complete home studies within the 60-day timeline for New Hampshire residents applying to serve a specific out-of-state child.	Quarter 1	

• Utilize transfer meetings to transition newly licensed families to the local office. • Analyze data and/or surveys and/or focus groups on a quarterly basis to actively monitor, manage, and improve the Division's licensing process over time b) DCYF will update the licensing requirements for foster and adoptive parents to improve consistency and safety, and reduce unnecessary barriers to licensing while working toward compliance with Family First mandates: • Update uniform statewide standard for fire inspections required for licensed foster family homes through legislative amendments to RSA 170-E: 28 and 34 • Submit proposed administrative rule changes to the legislature for approval. c) DCYF will introduce new, clear and consistent expectations for assessing, unlicensed relative caregivers to ensure the safety of children placed in those homes. • Create safety screening questions to preliminarily approve a relative home for placement; • Safety screening questions will be incorporated into the Relative Care Agreement form, which is reviewed and acknowledged by all relative caregivers upon placement.	Quarter 1/ Ongoing Quarter 1 Quarter 3 Quarter 1 Quarter 2	
2. DCYF will improve retention of foster parents and improve placement stability for children in foster care through responsive communication. a) DCYF will re-focus the role of the DO Resource Worker as the primary source of support for catchment area foster families in order to build and sustain strong relationships. • Administration will set expectations to reduce other duties that are not in alignment with Resource Worker's specialized job description. • Support maintenance of the refocused role of resource workers through monthly meetings with permanency supervisors	Quarter 1 Quarter 2 Quarter 2/ Ongoing	

	b) Administration will set expectations that CPSW and JPPOs will improve placement stability for children in placement through: a. Providing proactive and responsive communication to support placement stability; and b. Connect families to the community and/or provide, information and referrals to support the placement based on identified needs.	Quarter 1 Quarter 1	
3.	DCYF will collaborate with the Child Welfare Education Partnership to enhance initial and ongoing caregiver training for foster parents. a) Update FACES curriculum to include greater emphasis on working with birth parents, trauma-informed care (including potentially expanding training hours as required) • Explore utilizing more "team teaching" to involve non-foster parents in FACES and ensure messaging aligned across individual FACES classes • Utilize Birth Parent/Youth Training Coordinator to recruit additional birth parent and youth participation in FACES and ongoing trainings. b) Explore "tracks" of training to provide more customized support and messaging to foster, adoptive, relative c) Utilize customer satisfaction surveys to determine if improvements are needed for ongoing initial FACES scheduling and ongoing training delivery methods to make more accessible for families. d) DCYF and Child Welfare Education Partnership will explore the possibility of a minimum refresher requirement such as re-taking the Regulations training for foster parents to be completed every six years, prior to re-licensure. e) In order to support training, DCYF Resource workers will: • Co-develop an individual training plan with foster parents based on needs identified during their placements, which will outline trainings they will take toward their next foster care license. DCYF Resource Worker will support foster parents around navigating the Child Welfare Education Partnership website to	Quarter 4 Quarter 4 Quarter 4 Quarter 4 Quarter 4	

	ensure that foster parents are aware of current course offerings.		

Progress to Date

Over the last year, DCYF Staff and supporters have tirelessly advocated to strengthen New Hampshire's service array. Over the next year, DCYF plans to expand the DCYF Foster Care Health Program to include additional nurses imbedded within every district office, providing consultation, healthcare oversight, and coordination for all children and youth in placement.

DCYF continues to explore options to support the development of community-based voluntary services, for families referred by DCYF, and their children are at high risk for maltreatment or removal. The voluntary services expansion will occur in tandem with the redesign the DCYF community-based service array. In order to streamline the reporting of data by and feedback to paid providers, a focus group gathered provider's feedback on what to report on and how to best use the data in the future. This information will help to identify data points to update, change or add. A Request for Information (RFI) was submitted, inquiring of the community who might be able to provide this service. Proposals are due back by November 7, 2019.

DCYF is currently contracting with seven Master Licensed Drug and Alcohol Counselors supporting the 12 District Offices including the MLADC Supervisor. In FY2019, Project First Step, which oversees MLADCs, provided services to 71% of referrals, approximately 615 families.

On December 11, 2018, DCYF held statewide end of the year celebration for the *Parent Partner Program/Strength of Succeed Program.* Over fifty people came together to celebrate family voice and partnerships. Twenty Parent Leaders and twenty-five DCYF staff were joined by senior executive leadership of the Division, and the State including Governor Sununu to celebrate the collective efforts to partner with NH families to empower parents, strengthen families, and keep children/youth safe and thriving. In June, 2019, the State of NH, DCYF and the Gorham Family Resource Center, through their program Strength to Succeed, held its first Family Unification Month[8] celebration at the Berlin DO. Twelve families celebrated their work toward achieving sobriety and recovery and achieving reunification despite. The Parent Partner Program was also highlighted for their work to partner with and support families who have been through the child welfare system,

[8] *Family Unification Day coverage on WMUR.* https://www.wmur.com/article/program-that-pairs-parents-in-recovery-with-those-struggling-to-get-sober-showing-success/28441769

with new families with the goal of those families have more positive experiences working with the child welfare system

In November 2018, DCYF made changes to the Central Inquiry Unit for fostering, creating one position to support new foster parents through the process of completing required paperwork and training in an effort to streamline the process. Through recent evaluation, it was determined that there were still delays in foster parents moving through the process. Over the last year, the Central Inquiry Unit has implemented a revised process to further streamline the process. Currently, a home study practitioner is assigned to a prospective foster family once they have completed the required safety checks (criminal background checks, health and fire inspections). This allows more practitioners to support and encourage foster parents through the process of becoming licensed. Currently the Home Study Unit is comprised of eight and a half practitioners, both foster care practitioners and ICPC practitioner. The unit has also recently taken on the task of supporting writing home studies for relative care providers as requested by the local district offices. The roles of the local District Office Resource Workers is in the process of being re-focused, allowing them to prioritize case management of their foster homes and recruitment. The foster care program, and field supervises staff are working hard to ensure good communication around expectations for District Office Resource Workers in order to ensure consistency and continuity within their roles, and support to foster parents.

DCYF has re-designed a permanency position to focus on reunification. The Reunification Specialist attends office FAIR and Permanency Planning Team meetings in an effort to support ongoing reunification efforts. The intention is that enhanced attention on reunification will result in increased reunifications, and less children finding permanency outside of their home.

The adoption and post adoption unit previously focused on providing post-adoption services to families, however over the last year the focus has been more on a preventative approach by identifying families pre-adoption who need additional supports, and providing those supports before the adoption is finalized in an effort to reduce the number of disrupted adoptions.

In October 2019, DCYF and the Child Welfare Education Partnership held their annual Foster and Adoptive Parent and Relative Caregiver Conference. The theme of the conference was *Parenting Together- Fostering a Child's Village*. Workshops centered around the theme of building cooperative partnerships between caregivers and parents, as well as other opportunities for helping youth to achieve their goalas such as becoming a mentor, primary caring adult or CASA GAL and self-care for caregivers.

Part Two: CFSR PIP MEASUREMENT PLAN

Date Submitted: October 25, 2018
Date Resubmitted: March 28, 2019
Date Resubmitted: June 28, 2019
Date Resubmitted: October 3, 2019

New Hampshire proposes to have the Bureau of Organizational Learning and Quality Improvement (BOLQI) staff along with stakeholders, department of Health and Human services Staff, Juvenile Justice staff, Child Protection staff and other Division for Children, Youth and Families staff complete case practice reviews that will be used to measure performance for the Child and Family Services Review (CFSR) items.

BOLQI has a well-functioning statewide quality assurance and improvement process that encompasses the five areas of the quality assurance systemic factor in which New Hampshire successfully achieved. The quality assurance and improvement activities are driven by, and inclusive of, data collection, research and analysis, practice reviews and improvement, policy development, and training. The intentional positioning of the training, policy, data, quality assurance, and improvement functions within one Bureau, has allowed BOLQI to lead and influence continuous quality improvement (CQI) throughout all Bureaus and areas of practice, and ensure that learning in one area is leveraged in another.

New Hampshire participated in the traditional process in the CFSR for Round 3. As such, New Hampshire proposes to gather data and determine the baseline through a year of reviews conducted. Once a baseline is established, New Hampshire will apply the required methodology to determine PIP progress for each item.

An integral component of performance measurement and accountability in New Hampshire is the Case Practice Reviews and Assessment Reviews. The Administration for Children and Families' (ACF) CFSR framework and Online Monitoring System (OMS), and the Division for Children, Youth and Families' Assessment Review tool are fundamental instruments of reviewing New Hampshire child welfare practice and continuous quality improvement.

New Hampshire has utilized the Case Practice Review process to evaluate performance outcomes for safety, permanency and well-being for both Child Protective Services' and Juvenile Justice Services' cases. Specifically, New Hampshire has continued to mirror the federal CFSR by using the federal OMS on a case selection drawn similarly to the CFSR.

BASELINE AND CASE PRACTICE REVIEW

New Hampshire will use the pre-approved PIP item measurement approach method 2 to develop the baseline data through using prospective data and establish goals during the PIP implementation (see Appendix A). New

Hampshire will review 65 cases over a 12-month period, using the OMS to complete the Onsite Review Instrument (OSRI). Sixty percent (60%) of the cases will be foster care and forty percent (40%) will be in home service cases. The initial 65 cases will be used to establish New Hampshire's baseline performance scores and corresponding PIP goals for each item. Additionally, the baseline data will be used to determine the number of applicable cases per item.

Baseline Year			
	Total	FC	IH
CPR 1	22	14	8
CPR 2	22	13	9
CPR 3	21	13	8
Total	**65**	**40**	**25**

During the Case Practice Review process, data is also obtained through stakeholder surveys and/or focus groups, which may be collected in written form and/or verbally. Stakeholder names will be provided by the offices and include persons representing a range of agencies, including courts, local school districts, Court Appointed Special Advocates, community mental health centers, domestic violence crisis centers, police departments, child health services, and the Division's service providers. Reviews will be conducted three times a year. All of the reviews will include cases statewide. The inclusion of all District Offices will ensure a full representation of the state's demographic population. New Hampshire proposes to use a rolling 12 month measurement period. This ensures there is statewide representation of the cases, investigations and population during each reporting period. It also allows older reviews to fall out of the reporting period, while most recent reviews to roll into the current reporting period.

Each year the number of cases reviewed will increase by five, including case specific stakeholder interviews. An oversample of cases will be reviewed, as needed, within each review if the initial number of cases does not meet the number of applicable cases per item required for each PIP measured item. This will ensure consistency with the applicable number of cases in the baseline across each site review and therefore, across the entire sample of cases.

Year 1			
	Total	FC	IH
CPR 1	**24**	14	10
CPR 2	**23**	14	9
CPR 3	**23**	14	9
Total	**70**	**42**	**28**

Year 2			
	Total	FC	IH
CPR 1	**25**	15	10
CPR 2	**25**	15	10
CPR 3	**25**	15	10
Total	**75**	**45**	**30**

Teams consisting of BOLQI staff, DCYF state office staff, stakeholders and/or peer reviewers trained by BOLQI staff using the OSRI and documented in the OMS will review cases. It is critical to obtain information from a variety of sources to get a full understanding of what occurred that affected the child and family outcomes in each of the cases; therefore, case reviews will include a review of electronic (SACWIS-NH Bridges and, when applicable, CCWIS- Granite Families) and paper case file(s) as well as interviews with key case participants. Interviews with key individuals involved in the case must be conducted unless they are unavailable or unwilling to participate. It is critical to have family voice represented during interviews including school age child(ren) and parents. Other key individuals include caregivers, foster parents, residential/group home staff, CPSW and/or JPPO. On a case by case basis other individuals who may have relevant information about the case and family may be interviewed including the Court Appointed Special Advocate, guardian ad litem, parent aide/other service providers or other family members. The Division's "Case Practice Review Case-Related Interview Guides and Instructions (see Appendix B) is used to prepare and conduct key individual interviews. This mirrors the CFSR interview guides and instructions with additional questions for data quality review. Once the reviewers have completed the tool, first and second level quality assurance will be completed by staff trained in quality assurance including field supervisors, DCYF administration and BOLQI staff. The Division has a case practice review quality assurance guide (see Appendix C) that is updated as needed after case practice reviews and provided to each reviewer at the mandatory training prior to the following case practice review. The guide and training ensure consistency in conducting quality assurance of the OSRI and review teams.

CASE SELECTION

New Hampshire plans to use rolling sample periods as the reviews will not all happen at the same time rather one will occur three different weeks throughout the year. A statewide random sample stratified by case type will be used. The samples will be selected from a random-ordered sample frame comprised of the state population of cases. The cases in the sample frame that are not selected for review may serve as substitutes to replace any selected cases that are eliminated before or during the review.

A uniform sampling process is used and begins with a random draw of placement cases from the entire state AFCARS universe file during the sample period. Placement cases are a sample of cases open at least 24 hours during the sample period of six months established by parameters of a Bridges (SACWIS) query and validated during the case selection process.

In-home cases are randomly selected from a sample of cases that were opened for services for at least 45 consecutive days during the sampling period or began a 45-day consecutive period during the sample period as established by parameters of the Bridges query. The latter would allow for in-home services cases to complete the 45-day period after the sample period ends within the period under review. In-home cases are defined as cases in which no child in the family was in foster care at any time during the period under review. Case types for the in-home sample may include: abuse, before court (B-case), child in needs of services (CHINS),

delinquency, guardianship, neglect, voluntary services or voluntary CHINS. Further, as part of the in-home case selection, no more than forty percent and no less than twenty-five percent of the cases will be investigations (assessments) open more than 45 days requiring a safety plan (case type –AS) during the sample period as established by parameters in a separate Bridges query. The results of the two in-home queries will be combined in order to finalize the random case sample and the parameters will be validated during the in-home case selection.

Review	Date	Sample Period	Period Under Review
BCPR1	October 14-18, 2019	10/1/2018 to 3/31/2019 (to 5/15/19 IH)	10/1/18 to 10/14/19
BCPR2	March 9-13, 2020	2/1/2019 to 7/31/2019 (to 9/14/19 IH)	2/1/19 to 3/9/2020
BCPR3	June 22-26 2020	6/1/2019 to 11/30/2019 (to 1/14/20 IH)	6/1/19 to 6/22/20
Y1CPR1	October 12-16, 2020	10/1/2019 to 3/31/2020 (to 5/15/20 IH)	10/1/19 to 10/12/20
Y1CPR2	March 1-5, 2021	2/1/2020 to 7/31/2020 (to 9/14/20 IH)	2/1/20 to 3/1/2021
Y1CPR3	June 21-25, 2021	6/1/2020 to 11/30/2020 (to 1/14/21 IH)	6/1/20 to 6/21/21
Y2CPR1	October 11-15, 2021	10/1/2020 to 3/31/2021 (to 5/15/21 IH)	10/1/20 to 10/11/21
Y2CPR2	March 7-11, 2022	2/1/2021 to 7/31/2021 (to 9/14/21 IH)	2/1/21 to 3/7/22
Y2CPR3	June 20-24, 2022	6/20/2021 to 11/30/2021 (to 1/14/22 IH)	6/1/21 to 6/20/22

The total cases will be distributed between Child Protection and Juvenile Justice, because the child welfare practice and expectations in New Hampshire are reflective of one another. In order to ensure there is not an overrepresentation of one field service over the other, there will be no fewer than forty percent and no greater than sixty percent child protection or juvenile justice cases either in the foster care or in home case samples. This would guarantee a minimum of forty percent of each field service represented in the total sample reviewed.

Random sampling provides each case to have the same probability of being selected from the population allowing each district office the potential to be represented in random samples as the cases are distributed across the state. In an effort to ensure the metropolitan area of Manchester is sufficiently represented in the case selection, the percentage of cases from the Manchester District Office reviewed for the baseline period will be maintained each measurement period within (plus or minus) five percentage points.

Cases must be selected in the order as they appear on the random sample for each review; there are circumstances where cases may be substituted or eliminated but all eliminations must meet the guidelines listed below.

CASE ELIMINATION OR SUBSTITUTION

Case substitutions from the random sample will be made under the following situations:

- An in-home case was not open for 45 consecutive days with no children in placement during the Period Under Review (PUR).

- An in-home case in which any child in the family was in foster care more than 24 hours during the PUR.
- A placement case in which a child was on a trial home visit during entire PUR.
- A case that was closed before the PUR.
- A placement case was not open or a child was not in placement for at least 24 hours during the PUR.
- A case in which the child was placed for the entire PUR in a locked juvenile facility or other placement that does not meet the federal definition of foster care.
- A case that appears more than one time on the list, or was already reviewed during the 12-month measurement period
- No more than three cases per Child Protective Service Worker (CPSW) or Juvenile Probation and Parole Officer (JPPO).
- A case open for adoption subsidy payment only and not open for other services.
- A case in which the child's adoption or guardianship was finalized before the PUR and the child is no longer under the care of the state child welfare agency.
- A case in which the target child reached 18 before the PUR.
- A case in which the target child is or was in the care and responsibility of another state, and New Hampshire is providing supervision through an Interstate Compact on the Placement of Children (ICPC) agreement.
- A case where none of the key individuals are available or willing to be interviewed.
- A field service (JJ/CP) is overrepresented in the case selection sample as noted above.

Case eliminations during the week of the case practice review may be approved if they meet the guidelines listed below:

- A case where none of the key individuals show up to be interviewed.
- Reviewers discover that one of the conditions listed above apply to the case.

Justification for elimination must be discussed with and approved by a Bureau of Organizational Learning and Quality Improvement Administrator. Case substitutions will be noted on the random sample selection document and case eliminations will be shared with the Children's Bureau on a semi-annual basis, or upon request.

CONFLICT OF INTEREST

In order to assure the integrity of the Case Practice Review process, reviewers must disclose any conflict or potential conflict of interest that they may have between their role as a reviewer and their regular employment and/or their knowledge of, or involvement with, the parties or cases under review.

"Conflict of Interest" is defined as an activity or association that creates an actual, direct and substantial conflict with the roles and responsibilities of employment. Departmental policy further defines the appearance of a conflict of interest to mean an activity or association that would lead a reasonable person to conclude that such activity or association would create a conflict of interest.

Whether or not a conflict or the appearance of a conflict exists depends upon a number of factors that may include the reviewer's role within the agency, the reviewer's relationship to the agency as well as the reviewer's regular job functions. Each case needs to be evaluated independently to determine if a conflict exists.

Circumstances that *may* present a conflict or the appearance of a conflict of interest include but are not limited to the following:

- If the reviewer participated or was involved with the case under review;
- If the reviewer was previously assigned to the District Office of the case that is being reviewed;
- If the reviewer is a contracted or vendor service provider for the Department in the case;
- If the reviewer is an employee of a service provider in the case;
- If the reviewer has personal knowledge of parties or the particular service providers in the case;

Case practice reviewers are instructed to disclose a known conflict or the appearance of a conflict of interest to BOLQI in advance of participation in the review whenever possible. In addition, a reviewer has the responsibility to disclose a conflict of interest or potential conflict of interest that becomes apparent during the course of the Case Practice Review.

Upon the disclosure of a conflict or potential conflict of interest, BOLQI will evaluate the particular circumstances to determine if a conflict exists and if so, whether the conflict precludes the reviewer's participation in the Case Practice Review for the District Office or precludes a reviewer from the review of a particular case.

ADDRESSING CONCERNS DURING THE REVIEW

The Bureau of Organizational Learning and Quality Improvement has a process established for responding to safety concerns that may be identified by reviewers and Quality Assurance staff during the Case Practice Review. The process is for responding to the Case Practice Reviewers and concerns that they identify regarding imminent danger or risk of harm to a family or community, based on case information being reviewed. If a reviewer hears information in an interview or observes something while interviewing that raises concerns about risk or the safety of a child, he/she will report the safety concerns once the interview has concluded (unless it is an emergency that requires you to immediately call 911). The process is as follows:

I. Case practice reviewers must make their concerns known to their assigned QA staff member or another member of the Quality Assurance team if their QA Staff is not available.
   A. The reviewer will present their concerns to the QA staff;
   B. Reviewers must maintain confidentiality and should not inform any other reviewers participating in the CPR of the case concerns;
   C. Reviewers will not contact anyone involved in the case (including the CPSW or JPPO) while the "Administrative Concern" is being reviewed by the QA staff or the Field Administrator; and

D. The reviewers will be available to respond to any questions prompted by the QA staff and Field Administrator/Supervisor.
E. The reviewers will continue to review the case unless instructed by BOLQI that the case has been eliminated.

II. If deemed necessary the QA staff will assist reviewers with making a report of abuse or neglect according to agency guidelines.
A. In order to make this report, the following individuals should be notified:
1. BOLQI assigned Quality Assurance Level 1 staff
2. Quality Assurance Level 2
3. District Office Field Administrator

III. Once an Administrative Concern is received, a specific order of contacts will be followed.
A. The QA staff assigned to the case practice reviewers will notify a QA level 2 staff that an administrative concern may have been identified and will discuss the details with the QA level 2 staff.
B. The QA level 2 staff will determine if the Field Administrator and/or Supervisor need to be made aware, and inform them appropriately.
C. The Field Administrator will review all available information and determine in consultation with the supervisor what actions need to be taken.
1. The Field Administrator may determine that there is no present concern; or
2. The Field Administrator may identify immediate actions or plans to be carried out by the District Office staff, or case practice review team if a report is to be made to Central Intake.
D. The Field Administrator will follow-up with the QA staff assigned to the case practice reviewers with feedback to provide the reviewers.
E. The QA staff assigned to the team is responsible to report to the case practice reviewers on updates available regarding the administrative concern they identified.
F. The QA level 2 staff are responsible for ensuring the BOLQI administrator or site lead is aware of the administrative concern.
G. The BOLQI administrator or site lead will document the administrative concern in the log

REPORTING MEASUREMENT PROGRESS

New Hampshire Division for Children, Youth and Families will be monitoring and measuring the results of each case practice review following each review in the Online Monitoring System and will roll the measurement periods after each review following the baseline period. The results of the onsite review instrument for the case practice reviews will be available online and New Hampshire will report on the progress on the measurement plan to the Children's Bureau on a semi-annual basis each year after the Program Improvement Plan is approved.

APPENDIX A

Child and Family Services Review (CFSR) Round 3

New Hampshire: Program Improvement Plan (PIP) Measurement Plan Goal Calculation Worksheet

Case Review Items Rated an Area Needing Improvement (ANI) and Requiring Measurement Based on CFSR Findings and Technical Bulletin #9

Prospective Method Used to Establish PIP Baselines and Goals Using Case Reviews Conducted October 2019 through June 2020

CFSR Items Requiring Measurement	Item Description	Z value for 80% Confidence Level[1]	Number of applicable cases[2]	Number of cases rated a Strength	PIP Baseline[3]	Baseline Sampling Error[4]	PIP Goal[5]	Adjusted PIP Goal[6]
Item 1	Timeliness of Initiating Investigations of Reports of Child Maltreatment	1.28	TBD	TBD	TBD	TBD	TBD	TBD
Item 2	Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry Into Foster Care	1.28	TBD	TBD	TBD	TBD	TBD	TBD
Item 3	Risk and Safety Assessment and Management	1.28	TBD	TBD	TBD	TBD	TBD	TBD
Item 4	Stability of Foster Care Placement	1.28	TBD	TBD	TBD	TBD	TBD	TBD
Item 5	Permanency Goal for Child	1.28	TBD	TBD	TBD	TBD	TBD	TBD
Item 6	Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement	1.28	TBD	TBD	TBD	TBD	TBD	TBD
Item 12	Needs and Services of Child, Parents, and Foster Parents	1.28	TBD	TBD	TBD	TBD	TBD	TBD
Item 13	Child and Family Involvement in Case Planning	1.28	TBD	TBD	TBD	TBD	TBD	TBD
Item 14	Caseworker Visits With Child	1.28	TBD	TBD	TBD	TBD	TBD	TBD
Item 15	Caseworker Visits With Parents	1.28	TBD	TBD	TBD	TBD	TBD	TBD

Explanatory Data Notes:

[1]Z-values: Represents the standard normal (Z) distribution of a data set and measures the number of standard errors to be added and subtracted in order to achieve the desired confidence level (the percentage of confidence we want in the results). In order to have 80% confidence in the results of the sample data, a Z-value of 1.28 is used to calculate the margin of error.

[2]Number of Applicable Cases: Identifies the minimum number of applicable cases reviewed for the baseline period. Measurement samples must be equal to or greater than the number of applicable cases used to establish the baseline for each item. A two percent (2%) tolerance is applied to the number of cases reviewed to measure goal achievement compared to the number of cases reviewed to establish the baseline.

[3]PIP Baseline: Percentage of applicable cases reviewed rated a strength for the specified baseline period.

[4]Baseline Sampling Error: Represents the margin of error that arises in a data collection process as a result of using a sample rather than the entire universe of cases.

[5]PIP Goal: Calculated by adding the sampling error to the baseline percentage.

[6]Adjusted PIP Goal: Identifies the adjusted improvement goal that accounts for the period of overlap between the baseline period and the PIP implementation period. The adjustment is calculated using an adjustment factor that reduces the sampling error up to one half based on the number of months of overlap, up to 12 months. Percentages computed from at least 12-months of practice findings are used to determine whether the state satisfied its improvement goal. To determine a PIP measurement goal using case review data is met, CB will also confirm CB has confidence in accuracy of results, significant changes were not made to the review schedule, the minimum number of required applicable cases for each item were reviewed, the ratio of metropolitan area cases to cases from the rest of the state was maintained, and the distribution and ratio of case types was maintained for the measurement period. A five percent (+/-5%) tolerance is applied to the distribution of metropolitan area cases and case types between the baseline and subsequent measurement periods. When a state has an improvement goal above 90% and is able to

sustain performance above the baseline for three consecutive quarters, the Children's Bureau will consider the goal met even if the state does not meet the actual goal.

APPENDIX B

Case Practice Review Case-Related Interview Guides and Instructions

Introduction: CPR Case-Related Interviews
Child/Youth Interview
Parent/Caregiver Interview
Foster Parent Interview
Caseworker Interview

Introduction: CPR Case-Related Interviews

Through the Case Practice Review, we want to have a full understanding of what occurred that affected child and family outcomes in a particular case. It is critical to obtain information from a variety of sources before making initial determinations about outcomes. Case-related interviews with key individuals involved in the case serve as an opportunity to determine what has occurred in the case, confirm case record documentation, collect information that might be missing from the record, and obtain input about case participants' experiences. The interview information is weighed equally with information obtained from the case file documentation.

When interviewing persons important to the case, reviewers are responsible for asking questions relevant to the items in the Onsite Review Instrument (OSRI). Sometimes, information obtained during an interview may conflict with the documentation contained within the case record or obtained from another interview. In these cases, reviewers have a responsibility to pursue the issue across multiple interviews until they can determine the most accurate response to the relevant item questions.

Required Interviews with Key Case Participants

When scheduling interviews with key case participants, states should keep in mind that there are often multiple parents and/or caregivers who should be included in the review process. Ensuring that all of the relevant participants in the case are available for interviews is critical for a successful review process.

The following individuals related to a case will be interviewed unless they are unavailable or unwilling to participate:

- The child (school age)
- The child's parent(s) and/or caregivers
- The child's foster parent(s), pre-adoptive parent(s), or other caregiver(s), such as a relative caregiver or group home staff, if the child is in foster care
- The family's caseworker (when the caseworker has left the agency or is no longer available for interview, it will be necessary to schedule interviews with the supervisor who was responsible for the caseworker assigned to the family)

As needed, on a case-by-case basis, other individuals who have relevant information about the case also may be interviewed, such as the child's guardian ad litem or advocate, a parent's significant other, or other family members.

Preparing for Interviews and Using Interview Guides

Case-related interviews should be scheduled to take place after reviewers have had an opportunity to thoroughly review case record documentation. This allows reviewers to explore relevant issues and confirm or verify information found in the case record with each person interviewed.

The attached Interview Guides have been developed for key case participant interviews (Child(ren), Parents/Caregivers, Foster Parents, and Caseworkers). The guides include suggested language for introducing the interview process to the interviewee as well as specific questions that cover the key areas in the OSRI that should be informed by case participant information. The questions in the guides can be modified to fit the specific needs of participants as well as the circumstances of the case. The Children's Bureau strongly recommends that the guides be used for interviews to ensure

that adequate and consistent information is gathered through the interviews across the sample of cases being reviewed. Reviewers are encouraged to review the guides before interviewing case participants so they can highlight questions that they plan to ask and develop additional questions that may be needed based on case specifics.

Conducting Interviews

When the interview begins:

1. Introduce yourself and the interview process. Let interviewees know the approximate amount of time the interview might take. You may find that you normally spend about 30 to 45 minutes in your interviews, although the interview with the caseworker will likely take longer. Let the participant know in advance that you will need to take notes while he or she is talking. You should not record any interviews.

2. Provide an overview of the review process. Provide individuals with a brief overview of the purpose of the review process and the interview. Explain that the federal and state governments are looking at how well the state is helping children and families achieve positive outcomes. Let parents or foster parents know that you are interested in learning about their experiences because that will help to determine how the state can better support children and families.

3. Reassure participants of confidentiality. Emphasize that particular individuals will not be identified by name in any report. Reinforce participants' confidence in confidentiality by not revealing the comments of other persons interviewed, particularly those involved with the family. Stressing confidentiality is particularly important when interviewing children, parents, or foster parents. Note, however, that if concerns arise regarding the safety of the child, such concerns become subject to mandatory reporting laws. In addition, situations that you believe put the child at risk, such as individuals of whom the agency was not aware living in the home with the child or caregivers allowing a child in foster care to have visits with a non-custodial parent without the knowledge of the state, must be reported to the agency.

4. Explain your neutrality. Another important concept for your interviewees to understand is that you are a neutral reviewer with no ability to affect the case that you are reviewing. This is especially important when you are interviewing birth parents, who may see you as someone who can intervene on their behalf in a case plan or a case's goals. You'll need to be very clear that your role is not to specifically help or advocate for them, but to help the state know how to better meet the needs of families in the future. While you should acknowledge complaints raised by interviewees, you should not commit to checking on their situation or to getting back in touch with them.

5. Be flexible in your interview style and approach. Also, as you know, your interviewees may cross the spectrum from child to grandparent to therapist. You'll need to be very flexible in your interview styles to accommodate the particular parties that you're interviewing. At the same time, remain focused on what you need from each interview so that you obtain critical information while still using your limited time as efficiently as possible.

6. Get caseworker contact information. We advise you to ask the caseworker for a phone number during the interview, and to ask if you may call him or her if further information is needed. Many reviewers find that they need to contact the caseworker again after the initial interview to ask for clarification or obtain further information, particularly if the caseworker is one of their earlier interviewees.

7. Data Quality Review. As part of the review, a component is to validate data quality documented in the child welfare information system. It is important to ask the child/youth, parents and placement providers (as applicable) demographic information (including: full name, date of birth, race/ethnicity and the location where they live) and document.

Post-Interview Activities

Once the interviews have concluded:

1. Immediately report child safety concerns. If you hear information in an interview or observe something while interviewing that raises concerns about risk or the safety of a child, immediately report that concern to the lead person in charge of the case review (unless it is an emergency that requires you to immediately call 911).

Always strive to ensure that children are not upset by these interviews; normally, they aren't. If a child appears upset after an interview, be sure to immediately tell the review leader so that the state can respond to the situation by providing

support to the child.

2. Schedule additional interviews as needed. You may discover that additional interviews beyond those scheduled are needed to complete a thorough case record review. If this happens, immediately consult with the case review leader about the possibility of scheduling a new interview. Depending on where you are in the review process and with your case load, this may or may not be possible.

3. Review and compare interview and case record documentation. Once you complete all of the interviews, consider all the information gathered and begin to consider your assessment of each item in partnership with your assigned QA team member(s). Further, validate the information provided by the interviewees regarding all demographic information (including: name, date of birth, race/ethnicity and address) in the computer system. Document whether the information in the computer matches what the interviewees reported.

Child/Youth Interview

Because the Case Practice Review are focused on outcomes for children and families, hearing first-hand from children about their experiences is a crucial part of the review process. Questions to be used in interviews with children will vary depending on age, development, and the circumstances of the case. Reviewers should use their professional judgment when determining which topics to cover and how to phrase questions, but every effort should be made to obtain as much information as possible from children and youth about their experiences. Reviewers should be prepared to ask additional questions not included in this guide to clarify or verify information that was found in case documentation or obtained through other interviews.

When beginning the interview, start by explaining the purpose of the interview and asking about the child's understanding of his or her involvement with the agency. The following example can be modified based on the age of the child/youth:

> *Thank you for talking with me today. We are here to make sure that children who are involved with the child welfare agency get the best services they can, so I'm here to ask you about the kinds of services you received during [provide dates of the period under review, or depending on age of child just say "the past year"] and what your experiences were like as you worked with your caseworker. I'm not going to share what you tell me with your caseworker. I want to encourage you to be open and honest with me as I ask you questions because this information will be used to give the agency feedback about how they can improve their services. I understand that some of these questions or topics may be difficult to talk about, so please feel free to respond in whatever way you are most comfortable, and if you prefer not to answer a question, just let me know. Do you have any questions about this process? I have some specific questions to ask you, but before I start, can you tell me why the agency is/was involved with your family?*

Use the item focus (in bold below) as a way of explaining to the child what the questions will be about as you move from item to item. Again, depending on the child's age, you should explain that he or she should respond to the questions based on experiences within the dates of the period under review or just within the last year.

Item 3—**Ask about the child's experience during the period under review, whether he or she felt safe, and whether the agency was checking in about safety.**

For in-home cases: Did/do you feel safe in your family home? If not, what was/is going on to make you feel unsafe? [If necessary, ask about specific risk and safety concerns present during the period under review.]

For foster care cases: Did/do you feel safe in your foster home? During visits with your family? If not, what was/is going on to make you feel unsafe? [If necessary, ask about specific risk and safety concerns present during the period under review.]

Did you share any concerns about how you were feeling with the caseworker? How did he or she respond?

When the social worker visited, did he or she meet with you privately during part of each visit? Did he or she ask if you felt safe in your home (or foster home), or during visits with your family?

Item 4—**Ask about the child's placement history during the period under review, reasons for any changes, and stability of current or most recent placement.**

Do you know why you had to move from [describe placement/foster home name] to [describe next placement/foster home name]? How did you feel about moving?

How do you feel about where you are living now (or where you were placed last)?

Item 5—**Ask about the appropriateness of the child's permanency goals during the period under review.**

Explain the current or most recent permanency goal to the child and ask how the child feels about the goal: is it what he or she wanted; why or why not?

Has anyone discussed [indicate the permanency goal] with you? If yes, what did you talk about?

Item 6—**Ask about the efforts made to achieve permanency for the child during the period under review.**

Do you know what the agency or the court did to try to make sure you could be (reunified/adopted/placed in guardianship, etc.)?

[If permanency was not achieved timely, older youth may provide input as to reasons for delays.] What do you think happened that made it hard for [specify goal] to happen sooner?

Item 7—**Ask about efforts made to place siblings in foster care together.**

Ask the child about his or her siblings, and their relationship.

If placed separately, ask about when that happened (initial placement or later); ask the child why he or she believes they are currently separated and what contact they now have.

Item 8—**Ask about the visitation arrangements for children with siblings and parents/caregivers.** How often do/did you visit with your parents? What about visits with siblings?

Where did visits take place?

How long were the visits? Did you feel they were long enough?

Were visits supervised? If yes, do you know why they were supervised?

Did you enjoy the visits? Is there anything that would have made visits better or more enjoyable for you and your parents and siblings?

Item 9—**Ask about the child's connections and how they were preserved during the period under review.**

Were any efforts made to ensure that you stayed connected with friends and family after you were placed in foster care?

What about other connections like church and school?

Do you have Native American heritage? Any Tribal affiliations?

Item 10—**Ask about efforts to identify, locate, inform, and evaluate both paternal and maternal relatives as placement resources.**

Did your caseworker ask you about relatives (maternal and paternal) that you could possibly be placed with?

Item 11—**Ask about efforts to promote, support, and maintain the child's relationship with parents/caregivers during the period under review.**

Aside from visitation, did you have any other contact with your parents? For example, did they come to school activities or attend doctor's appointments with you?

Items 12, 16, 17, and 18—**Ask about how the child(ren)'s needs were assessed (comprehensive, education, physical, dental, mental health), what needs were identified, and how services were provided to meet needs. (In-home cases should focus on all children in the home; FC cases should focus on just the target child.)**

Ask about any specific needs known to you (from items 12, 16, 17, and 18) and ask if the child was getting services to help. If the child is an adolescent, ask about assessment and services for independent living skills.

If no known needs, ask generally: Did you participate in any activities or services? For example, afterschool programs, counseling or therapy, mentoring, sports, tutoring, special education services.

Was there anything you wish your caseworker had helped you with?
How are you doing in school?
Did you have any health or dental problems that the caseworker did not attend to?

Optional questions for older child/youth, depending on case circumstances: Ask about how the parents' needs were assessed, what needs were identified, and how services were provided to meet needs. Do you think your parents received the services and help that they needed to take care of you and keep you safe? Is there anything you think they needed help with that they didn't get?

Optional questions for older child/youth: Ask about how the foster parents' needs were assessed, what needs were identified, and how services were provided to meet needs.

Do you think your foster parents had what they needed in order to take good care of you?
Is there anything you think they needed help with that they didn't get?

Item 13—**Ask about how the child was involved in case planning.**

Did the caseworker talk to you regularly about what was happening in your life, asking you questions about how you were doing and what you may have needed?
Were you involved in any meetings where your case plan was discussed?

Item 14—**Ask about the frequency and quality of the caseworker's visits with the child.**

How often did your caseworker visit you?
Where did you usually visit?
What did you talk about?
About how long were the visits?
Were the visits helpful for you?
If you ever needed to talk to your caseworker, were you able to contact him or her?

Complete the interview by thanking the child/youth for his or her time and asking if there is anything else he or she would like to share with you.

Parent/Caregiver Interview

Because the Case Practice Review are focused on outcomes for children and families, hearing first-hand from parents/caregivers about the outcomes they have experienced is a crucial part of the review process. Questions to be used in interviews with parents/caregivers may vary depending on the circumstances of the case. Every effort should be made to obtain as much information as possible from parents and/or caregivers about their experiences. Reviewers should be prepared to ask additional questions not included in this guide, to clarify or verify information that was found in case documentation or obtained through other interviews.

When beginning the interview, start by explaining the purpose of the interview and asking about the parent/caregiver's understanding of his or her involvement with the agency. The following is an example:

Thank you for taking the time to talk with me today. We are conducting a review of the services provided to children and families by [agency name]. The goal of the review is to provide feedback to (agency name) about how they can make improvements in their system so that children and families have the best outcomes. I'm here to ask you about the kinds of services you received during [provide dates of the period under review] and what your experiences were like as you worked with the agency. The information you share with me is confidential and will not be shared with your caseworker, so it will not have any impact on your case. I want to encourage you to be open and honest with me as I ask you questions because your feedback is a very important part of this review process. I understand that some of these questions or topics may be difficult to talk about, so please feel free to respond in whatever way you are most comfortable and if you prefer not to answer a question, just let me know. Before we begin, do you have any questions about the interview or the review process? I have some specific questions to ask you, but before I start, can you tell me why the agency is/was involved with your family?

Use the item focus (in bold below) as a way of explaining to the parent/caregiver what the questions will be about as you

move from item to item.

Items 2 and 3 [Ask these questions to assist in determining whether item 2 is applicable for assessment]—**Ask about how the agency assessed risk and safety during the period under review and what concerns were present in the case during the period under review.**

What is/was your understanding of the risk and safety concerns that existed during the period under review? What kinds of things did the caseworker look for or ask about in order to determine that those concerns were being resolved?

Did you have a safety plan developed for your family? If so, can you talk about the plan? How was it monitored?

[This question should be asked on all in-home cases, and should be asked in foster care cases in which the child entered foster care during the period under review or was reunified during the period under review.] Were services offered to your family to keep your children safe in your home? If not, do you know why not?

[For foster care cases] Did you have any concerns about the safety of your child while he or she was in foster care?

[If the case was closed during the period under review]—Can you describe what happened when your case was closed? For instance, did the caseworker come to your home and have a final conversation with you?

Item 5—**Ask about the appropriateness of the child's permanency goals during the period under review.**

What was/were the permanency goal(s) for your child when he or she was first removed from your home? What is the current permanency goal for your child? [Parents may not be familiar with the term "permanency goal," so provide examples and explain goals like reunification/return home, adoption, etc.]

Did the caseworker discuss the permanency goal(s) with you? If so, can you tell me what those conversations were like? [If permanency goals changed during the period under review and/or there were concurrent goals in place]—Do you think the goals in place during the period under review were appropriate for your child based on what was happening with the case and the child's needs?

Item 6—**Ask about the efforts made to achieve permanency for the child during the period under review.**

What did the agency or the court do to try to ensure that your child achieved the goal of [indicate the child's permanency goal]?

[If permanency was not achieved timely]—What were the barriers that you experienced in achieving [indicate permanency goal] in a timely manner?

[If the child had concurrent goals]—What was your understanding of the concurrent plan of [name concurrent goal]? How did the caseworker explain that to you?

Item 7—**Ask about efforts made to place siblings in foster care together.**

Were any of your children placed in separate foster homes? If so, do you know why?

Do you know what efforts the agency made to place them together?

Item 8—**Ask about the visitation arrangements for children with siblings and parents/caregivers.**

Was a visitation plan developed for you and your children? If so, were you involved in developing it?

What was the frequency of visitation and how was frequency determined?

Where did visits take place? How was the location of visits determined?

How long were the visits? Did you feel they were long enough?

Were visits supervised? If so, how and why?

[If children were placed in separate foster homes]—Did your children have visits with their siblings in addition to visits with you?

Is there anything that would have made visits better for you and your child?

Item 9—**Ask about the child's connections and how they were preserved during the period under review.**

• Were any efforts made to ensure that your child stayed connected with friends and family after they were placed in foster

care?
• What about other connections like church and school?
• Does your child have Native American heritage?

If yes, is the child a member or eligible for membership in an Indian Tribe? If yes (if the child came into foster care during the period under review or had a TPR hearing during the period under review), were efforts made to notify the Tribe about foster care placement and/or TPR hearings?
If unsure, did the agency make any efforts to determine the child's eligibility for membership?

Item 10—**Ask about efforts to identify, locate, inform, and evaluate both paternal and maternal relatives as placement resources.**

Did the worker ask you about relatives (maternal and paternal) with whom your child could possibly be placed?
What other efforts did the agency make to find and/or place child with relatives?

Item 11—**Ask about efforts to promote, support and maintain the child's relationship with their parents/caregivers during the period under review.**

What efforts, aside from visitation, were made to support and strengthen your relationship with your child while he or she was in foster care? For example, were you encouraged to participate in school activities and case conferences, attend doctor's appointments or engage in the child's extracurricular activities? What kinds of interactions (if any) did you have with your child's foster parents? Were you offered or provided with transportation or transportation funds to participate in events/appointments with your child?

Item 12—**Ask about how the child(ren)'s needs were assessed, what needs were identified, and how services were provided to meet needs. (In-home cases should focus on all children in the home; FC cases should focus on just the target child.)**

Do you believe the agency accurately assessed your child(ren)'s needs during the period under review?
What kinds of services did your child(ren) receive? Were the services helpful?
Was there anything your child(ren) needed that the agency did not provide for?

Ask about how the parent's needs were assessed, what needs were identified, and how services were provided to meet needs.

Do you believe the agency accurately assessed your needs during the period under review?
How did they assess your needs? What kinds of questions were you asked?
What kinds of services did you receive?
Were the services helpful to you? How were they helpful?
Were services easily accessible?
Was there anything you needed that the agency did not provide for?

***(Optional, if the parent/caregiver has a relationship with the foster parents)*—Ask about how the foster parents' needs were assessed, what needs were identified, and how services were provided to meet needs.**

How were the foster parents' needs assessed during the period under review?
Did the foster parents have any needs related to their ability to care for the child in their home?
Were any services provided to the foster parents?
Were there any barriers to accessing services?
Was there anything the foster parents needed that they were not provided with?

Item 13—**Ask about how the child, mother, and father were engaged in case planning.**

Were you able to provide input in developing your case plan?
What types of conversations did you have with the caseworker about your case plan? How frequently did the caseworker discuss the case plan with you?
Did you understand the purpose and content of your case plan? Did you have a copy of your plan?
How was your child involved in case planning activities?

Item 14—**Ask about the frequency and quality of the caseworker's visits with the child.** (Applicable for in-home

cases and may be applicable for FC cases as well)
How frequently did the caseworker visit the child(ren) during the period under review?
Where did visits typically occur?
If you were present during the visit, what was discussed?
Did the worker visit with the child(ren) alone?
Typically, how long were the visits?
Did the child(ren) have regularly scheduled visits or were visits prompted by other things?

Item 15—**Ask about the frequency and quality of the caseworker's visits with the parents/caregivers.**
How frequently did the caseworker visit you? Did you feel they were frequent enough?
Where did visits occur?
What was discussed during visits?
Typically, how long were the visits? Did you feel they were long enough?
Did you have regularly scheduled visits or were visits prompted by other things?
Did you feel like your caseworker was accessible to you?
Were you able to talk about things during your visit that you felt were important, regarding your child(ren) and your case?

Item 16—**Ask about how the child's educational needs were assessed and met.**
Did you have any concerns about your child(ren)'s education during the period under review?
Did your child(ren) need or receive any special services?

Item 17—**Ask about how the child's physical and dental health needs were assessed and met.**
Did you have any concerns about your child(ren)'s physical health during the period under review?
Did they need or receive any services?

Item 18—**Ask about how the child's mental health needs were assessed and met.**
Did you have any concerns about your child(ren)'s mental or behavioral health during the period under review?
Did they need or receive any services?

Complete the interview by thanking the parent/caregiver for their time and asking them if there is anything else they would like to share with you regarding their experience.

Foster Parent Interview

Because the Case Practice Review are focused on outcomes for children and families, hearing first-hand from foster parents about the outcomes they have experienced is a crucial part of the review process. Questions to be used in interviews with foster parents may vary depending on the circumstances of the case and how long they had the child in their care. Every effort should be made to obtain as much information as possible from foster parents about their experiences and the experiences of the child in their care. Reviewers should be prepared to ask additional questions not included in this guide to clarify or verify information that was found in case documentation or obtained through other interviews.

When beginning the interview, start by explaining the purpose of the interview. The following is an example:

> *Thank you for taking the time to talk with me today. We are conducting a review of the services provided to children and families by [agency name]. The goal of the review is to provide feedback to [agency name] about how they can make improvements in their system so that children and families have the best outcomes. I'm here to ask you about the kinds of services you and your foster child received during [provide dates of the period under review] and what your experiences were like as you worked with the agency. The information you share with me is confidential and will not be shared with your caseworker, so it will not have any impact on the case. I want to encourage you to be open and honest with me as I ask you questions because your feedback is a very important part of this review process. Before we begin, do you have any questions about the interview or the review process?*

Use the item focus (in bold below) as a way of explaining to the foster parent what the questions will be about as you move from item to item. Explain to the foster parent that he or she should respond to the questions based on experiences during the period under review, and mention the dates of that period.

Item 3—**Ask about any specific risk and safety concerns present in the case during the period under review.**
Did you have any concerns about the child's safety during visitation with parents and/or other family members?

Item 4—**Ask about the child's placement history during the period under review.**
[If the child is no longer in your home]—What was the reason for the child leaving your home? Is there anything that could have been done to prevent the child moving from your home?
[If the child is still placed with the foster parent]—Do you plan to continue to provide a home for the child as long as a placement is needed? Do you have any concerns with the child's current placement in your home or your ability to care for him or her?

Item 5—**Ask about the appropriateness of the child's permanency goals during the period under review.**
Did the caseworker discuss the child's permanency goal of [indicate specific goal/s] with you?
Do you believe the goal of [indicate permanency goal] is/was appropriate based on the child's needs and the circumstances of the case? Why or why not?

Item 6—**Ask about the efforts made to achieve permanency for the child during the period under review.**
What did the agency or the court do to try to ensure that the child achieved the goal of [indicate permanency goal] in a timely manner?
[If permanency was not achieved timely]—Do you know what the barriers were in achieving the goal of [indicate permanency goal] in a timely manner?

Item 7—**Ask about efforts made to place siblings in foster care together.**
Were any of the child's siblings placed in separate foster homes? If so, do you know why?
Do you know what efforts the agency made to place them together?

Item 8—**Ask about the visitation arrangements for children with siblings and parents/caregivers.**
Was a visitation plan developed for the family? If so, were you involved in developing it?
What was the frequency of visitation and how was frequency determined?
Where did visits take place? How was the location of visits determined?
How long were the visits? Did you feel they were long enough?
Were visits supervised? If so, how and why? [If children were placed in separate foster homes]—Did the child have visits with siblings in addition to visits with parents?
Did you have any concerns regarding visitation for the child? Is there anything that would have made visits better for the child?

Item 9—**Ask about the child's connections and how they were preserved during the period under review.**
Were any efforts made to ensure that the child stayed connected with friends and family after placement in foster care?
What about other connections like church and school?

Item 11—**Ask about efforts to promote, support, and maintain the child's relationship with parents/caregivers during the period under review.**
What efforts, aside from visitation, were made to support and strengthen the relationship between the child and parents/caregivers while he or she was in foster care? For example, were parents/caregivers encouraged to participate in school activities and case conferences, attend doctor's appointments, or engage in the child's extracurricular activities?
What kinds of interactions (if any) did you have with your child's parents/caregivers?
Were there any concerns with transportation for parents/caregivers to have additional contact with the child?

Item 12—**Ask about how the child(ren)'s needs were assessed, what needs were identified, and how services were provided to meet needs.**

Do you believe the agency accurately assessed the child's needs during the period under review?
What kinds of services did the child receive? Were the services helpful?
Was there anything the child needed that the agency did not provide for?

Ask about how the foster parents' needs were assessed, what needs were identified, and how services were provided to meet needs.
How often did the caseworker visit with you? What types of things were discussed during visits/contact with the caseworker?
Did you have any needs relating to your ability to care for the child?
Were you provided with any services? Were they helpful?
Were there any barriers to accessing services?
Did you have the training you needed to meet any specific needs of the child?
Was there anything you needed that you were not provided with?

Item 13—**Ask about how the child was engaged in case planning.**
Was the child able to provide input in developing the case plan? How was your child involved in case planning activities?
What types of conversations did the caseworker have with the child about the case plan? How frequently did the caseworker discuss the case plan with the child?
Did the child understand the purpose and content of the case plan?

Item 14—**Ask about the frequency and quality of the caseworker's visits with the child.**
How frequently did the caseworker visit the child during the period under review?
Where did visits typically occur?
If you were present during the visit, what was discussed?
Did the worker visit with the child alone?
Typically, how long were the visits?
Did the child have regularly scheduled visits or were visits prompted by other things?

Item 16—**Ask about how the child's educational needs were assessed and met.**
Did you have any concerns about the child's education during the period under review?
Were any educational needs appropriately assessed?
Were you provided with needed access to the child's school records?
Did the child need or receive any special services?

Item 17—**Ask about how the child's physical and dental health needs were assessed and met.**
Did you have any concerns about the child's physical or dental health during the period under review?
Is the child up to date with any needed immunizations, annual check-ups, periodic dental screenings?
Were you provided with or did you have access to the child's health records?
Did the child need or receive any services? If so, were they helpful and adequate to meet the child's needs?
Was the child on any medications? If so, how were they monitored?

Item 18—**Ask about how the child's mental health needs were assessed and met.**
Did you have any concerns about the child's mental or behavioral health during the period under review?
Did the child need or receive any services? If so, were they helpful and adequate to meet the child's needs?
Was the child on any medications? If so, how were they monitored?

Complete the interview by thanking the foster parents for their time and asking them if there is anything else they would like to share with you regarding their experience.

Caseworker Interview

Because the Case Practice Review are focused on outcomes for children and families, hearing first-hand from caseworkers about the work the agency has done with families is a crucial part of the review process. Every effort should be made to obtain as much information as possible from the caseworker and, in most cases, reviewers should include all of the

questions in this guide during their interviews. Reviewers should be prepared to ask additional questions not included in this guide, to clarify or verify information that was found in case documentation or obtained through other interviews.

When beginning the interview, start by explaining the purpose of the interview. The following is an example:

Thank you for taking the time to talk with me today about the [case name] case. As you know, we are conducting a review of the services provided to children and families by [agency name]. The goal of the review is to provide feedback to [agency name] about how they can make improvements in their system so that children and families have the best outcomes. As a caseworker, your work with children and families is extremely important and we want to be able to capture your experience in working with the family. In addition, we also want to understand how your agency works in collaboration with other state systems, like education, health, and the courts, in working to meet the needs of families. In addition to reviewing the case record, we will be conducting interviews with children, parents, and foster parents as well, so I may ask you some clarifying questions based on information that we have gathered about the case. The information you share with me is confidential, and I want to encourage you to be open and honest with me as I ask you questions because your feedback is a very important part of this review process. Our review is focused on a specific period of time [indicate the period under review], so when you provide your responses, please consider things that happened during that time period. Before we begin, do you have any questions for me about the interview or the review process? I have some specific questions to ask you, but before I start, can you provide me with a quick summary of why the agency is/was involved with this family?

Use the item focus (in bold below) as a way of explaining to the caseworker what the questions will be about as you move from item to item. Remind the caseworker that he or she should respond to the questions based on experiences during the period under review. If another social worker was responsible for a portion of the period under review and is not available to be interviewed, encourage the worker you are interviewing to respond as best as he or she can for the entire period.

General information to obtain: Confirm who the key case participants are who are being assessed as Mother, Father, and Foster Parents in the review. If the case involves birth parents who could not be located during the period under review, ask about the concerted efforts that were made to locate them.

Item 1—**Ask about the reasons for any delays in initiating investigations and/or completing face-to-face visits with victims.**

Based on documentation in the case record, verify with the social worker any noted delays in the investigation process.

What were the reasons for delays?

Items 2 and 3 **[Ask these questions to assist in determining if item 2 is applicable for assessment.] Ask about general practice for assessing risk and safety during the period under review.**

What did the assessment process involve?

Were specific assessment tools used?

Was your supervisor involved in reviewing assessments?

How often were assessments conducted?

Were assessments updated? If so, when/under what circumstances?

How were assessments documented (formal and informal)?

[If the case was closed during the period under review]—Did you do an assessment of risk/safety before case closure? If so, can you describe that process?

Ask about the specific risk and safety concerns present in the case during the period under review.

Can you describe any risk and safety concerns that existed during the period under review?

If safety concerns existed during the period under review, was a safety plan developed? How was it developed and monitored? Was it updated?

Were services offered to the family to address safety concerns and prevent foster care placement or re-entry after reunification? If not, why not?

If yes, what types of services were offered? How did the services address the specific safety concerns?

For foster care cases: Did any safety concerns exist for the child in care during visitation or in the foster care placement? If yes, what were the concerns? What did you do to ensure the safety of the child?

Item 4—**Ask about the child's placement history during the period under review.**

Verify the child's placement history during the period under review based on the case record documentation.
For each placement during the period under review, ask: How was this placement identified for the child? What was the reason for the change in placement?
How stable is the child's current placement?

Item 5—**Ask about the appropriateness of the child's permanency goals during the period under review.**

[If a goal is not documented in the case record]—What is/are the child's current permanency goal(s)?
Describe the goals in place during the period under review and ask for each goal: Was this the most appropriate goal for the child? Why?
What were the reasons for any goal changes? Discuss any concerns about the timeliness of establishing goals and/or changing goals.
[If the child had concurrent goals]—How was concurrent planning implemented in the case?
Obtain any clarification needed regarding filing for termination of parental rights, if applicable.

Item 6—**Ask about the efforts made to achieve permanency for the child during the period under review.**

Has or will the child achieve permanency within an appropriate time frame (12 months for reunification, 18 months for guardianship, 24 months for adoption)?
What efforts have been made by the court and the agency to achieve permanency in a timely manner?
For a child with the goal of "other planned permanent living arrangement," what formal steps have been taken to make the living arrangement permanent?
[If the child will not achieve permanency timely]—What were/are the barriers in achieving the permanency goal(s) timely?
Is there a justifiable reason for any delay in achieving permanency for the child [see examples in the OSRI]?

Item 7—**Ask about efforts made to place siblings in foster care together.**

Was the child placed separately from siblings? Why?
[If a valid reason for separation existed at one point during the period under review]—Were the circumstances for separate placement re-evaluated to consider if the siblings could be reunited?

Item 8—**Ask about the visitation arrangements for children with siblings and parents/caregivers.**

Was a visitation plan developed for the family? Who was involved in developing the plan?
What was the frequency of visitation and how was frequency determined?
Where did visits take place? How was the location of visits determined?
How long were the visits?
Were visits supervised? If so, how and why?
Did children have separate sibling visitation or was it only in the context of parent visitation?
What efforts did the agency make to support and encourage visitation?

Item 9—**Ask about the child's connections and how they were preserved during the period under review.**

What were the child's important connections?
What efforts were made to preserve these connections?
Has the child been maintained in the same school? If not, why not?

Does the child have Native American heritage? If yes, is the child a member of, or eligible for membership in, a federally recognized Indian Tribe?
[If yes, and the child came into foster care during the period under review or had a termination of parental rights hearing during the period under review]—What efforts were made to notify the Tribe about placement in foster care and/or termination of parental rights hearings? Was the child placed in

accordance with Indian Child Welfare Act placement preferences?
If unsure, what efforts were made to determine the child's eligibility for membership?

Item 10—**Ask about efforts to identify, locate, inform, and evaluate both paternal and maternal relatives as placement resources throughout the period under review.**

What efforts were made to identify, locate, inform, and evaluate maternal relatives as placement resources?
What efforts were made to identify, locate, inform, and evaluate paternal relatives as placement resources?
Were efforts made throughout the period under review or just when the child first came into care?

Item 11—**Ask about efforts to promote, support, and maintain the child's relationship with parents/caregivers during the period under review.**

What efforts, aside from visitation, were made to support and strengthen the child's relationship with parents/caregivers? For example, were parents encouraged to participate in school activities and case conferences, attend doctor's appointments, or engage in the child's extracurricular activities?
Were efforts made to support a relationship between the foster parents and the child's parents/caregivers so that they could serve as support system/mentors?
Were efforts made to provide transportation or transportation funds for the parents/caregivers to participate in events/appointments with the child?

Item 12—**Ask about how the child(ren)'s needs were assessed, what needs were identified, and how services were provided to meet needs. (In-home cases should focus on all children in the home; foster care cases should focus on just the target child.)**

[If the case was opened during the period under review]—Was an initial comprehensive assessment of the child(ren) conducted? How was the assessment done?
What needs were identified?
[If the case was opened before the period under review]—Were periodic comprehensive assessments conducted during the period under review to assess needs and inform case planning? How were assessments conducted?
What types of needs were identified and/or did the child's needs change during the period under review?
[If the child was exposed to domestic violence]—Was the child's exposure to domestic violence in the home assessed to determine if he or she needed further mental health assessment or services?
What services were provided for the child during the period under review?
How did these services meet the child's identified needs?
Were there any barriers to accessing services?

Ask about how the parents'/caregivers' needs were assessed, what needs were identified, and how services were provided to meet needs.

[If the case was opened during the period under review]—Was an initial comprehensive assessment of the mother/female caregiver and father/male caregiver conducted? How was the assessment done?
What needs were identified?
[If the case was opened before the period under review]—Were periodic comprehensive assessments conducted during the period under review to assess needs of the mother/female caregiver and father/male caregiver? How were assessments conducted?
What types of needs were identified and/or did their needs change during the period under review?
What services were provided for the mother and father during the period under review?
How did these services meet identified needs?
Were there any barriers to accessing services?

Ask about how the foster parents' needs were assessed, what needs were identified, and how services were provided to meet needs. (Cover all foster parents providing care to the child during the period under review.)

How were the foster parents' needs assessed during the period under review?
Did the foster parents have any needs related to their ability to care for the child in their home?

Were any services provided to the foster parents?
Were there any barriers to accessing services?

Item 13—**Ask about how the child and parents/caregivers were engaged in case planning. (Ask specifically for child(ren), mother, and father.)**

Describe the process you used to engage the parents/caregivers in case planning. How did you describe the purpose of the case plan to parents/caregivers?
How frequently did you engage parents/caregivers in case planning discussions?
What input did the parents/caregivers provide into the case plan?
Describe the process you used to engage the child(ren) in case planning. How did you describe the purpose of the case plan to the child(ren)?
What input did the child(ren) provide into the case plan?

Item 14—**Ask about the frequency and quality of the caseworker's visits with the child.**

How frequently did you visit the child during the period under review [refer to any available documentation of visits from the case record]?
Where did visits occur?
What was discussed during visits?
Did you visit with the child in the presence of parents, foster parents, or others?
Typically, how long were the visits?
Did you have regularly scheduled visits or were visits prompted by other things?

Item 15—**Ask about the frequency and quality of the caseworker's visits with the mother and father. (Ask questions for each parent/caretaker.)**

How frequently did you visit the mother/father during the period under review [refer to any available documentation of visits from the case record]?
Where did visits occur?
What was discussed during visits?
Typically, how long were the visits?
Did you have regularly scheduled visits or were visits prompted by other things?

Item 16—**Ask about how the child's educational needs were assessed and met.**

What is the child's current status in school (grade level, reading level)?
Were educational assessments conducted during the period under review? If so, how were they conducted?
What needs were identified?
What services (if any) is the child receiving and how are they meeting identified needs?
Are there any barriers to accessing needed services? What efforts has the agency made to access the services?

Item 17—**Ask about how the child's physical and dental health needs were assessed and met.**

[If the child entered foster care during the period under review]—Was an **Early Periodic Screening, Diagnosis, and Treatment** test or other medical examination conducted upon the child's entry into care?
When was the child's last physical and dental exam?
What physical and dental health needs does the child have?
What services (if any) have been provided to the child and are they meeting the identified needs?
Is the child on any medication related to physical health? If so, how is that being monitored?

Item 18—**Ask about how the child's mental health needs were assessed and met.**

1. During the period under review, did the child have or develop any mental or behavioral health needs?
2. How were they assessed?
3. What services were provided to meet the identified needs and are they meeting these needs?
4. Is the child on any prescription medications for mental health issues? If so, how is that being monitored?

Complete the interview by thanking the caseworker for his or her time and asking if there is anything else the caseworker

would like to share with you.

APPENDIX C

New Hampshire Division for Children, Youth and Families (DCYF) Case Practice Review Quality Assurance (QA) Guide September 2019

General Instructions:

- **"**Target child" is the language used to the identified child/youth in placement cases only. Siblings should be referred to as "Sibling 1", "Sibling 2", and so on.
- "Child 1", "Child 2", "Sibling 1", "Sibling 2" are terms that should be used in an in-home case to differentiate between child(ren)/youth(s).
- Any time an item is N/A, complete the optional box with the reason why it is not applicable.
- In Item 3, reviewers should give a brief history of the family including:
    - who is in the family (including all parents, children and household members who are legally related to the child(ren));
    - how the family is involved with DCYF;
    - who (if anyone) is petitioned;
    - the case [or assessment] type and abuse/neglect category (if applicable);
    - permanency goals/dates changed;
    - placement history of any petitioned child(ren)/youth (dates; including hospitalizations, reunifications, etc.);
    - dates of reunifications;
    - brief explanation of the family needs (i.e. substance abuse-mom; mental health-dad); and
    - closing date

SECTION I: FACESHEET

1. Reviewers can change all items on Facesheet except A, C & F once it is saved. However, once items are completed that reference case participants, they may not be able to delete those participants.
2. G2 Case participant table list all parents (bio or legal) regardless of their involvement and note in relationship column whether they were terminated or deceased prior to the PUR. This ensures that we do consider all parents
3. Be sure to enter the correct PUR dates as this is an item that cannot be changed without eliminating the case!
4. If a child/youth reunifies and the State does not retain custody, or there is not an order specifically stating it is a trial home visit, this ends the foster care episode. If a child/youth returns to out-of-home care under these circumstances, this should be considered a new removal and a new entry into foster care.

Date of Case Opening:

1. The date of the first case opening during the PUR should be answered as follows:
    a. JJS cases, date of adjudication unless the youth is placed or the court ordered services;
    b. CPS case opening date is when the case is open in Bridges.

c. The JJS practice during a Voluntary CHINS case prior to the period under review or while open as voluntary for a portion of the review is considered as part of the *history of agency involvement* but does not count toward the *open time period* for a court ordered services/ratings during the PUR.*

d. In a CPS assessment case, the time of case opening starts the date the assessment is assigned to the District Office

e. In a CPS voluntary services case, the time of case opening starts the date the case is opened on Bridges. If, a paid service is initiated in the associated assessment, the case opening date starts the day the paid service began.

***Reviewers should consult with their QA person on how this may impact ratings.**

SECTION II: SAFETY

SAFETY OUTCOME 1: CHILDREN ARE, FIRST AND FOREMOST, PROTECTED FROM ABUSE AND NEGLECT

Item 1: Timeliness of Initiating Investigations of Reports of Child Maltreatment

1. Confirm with reviewers that they included all reports received during the Period Under Review (PUR), including any reports that came in after the case was closed (if applicable).
2. Review the policies on state-specific priority response timeframes to ensure accuracy.
3. This item does NOT include screen outs.
4. Please complete the A1 Chart and the supporting questions. Put investigation, no assessment in the table. Don't forget to review the instructions for each question by clicking on the "show" link next to the question.
5. If there are no accepted reports during the PUR and/or the only reports were screened out, this item is Not Applicable (N/A). Please check the box indicating the item is N/A and provide explanation in the "Optional" box.
6. In the Item 1 rating area, Not Applicable should be automatically populated for you. The following page will show the rating outcome for Safety Outcome 1. This will also be completed for you. You can then proceed to Item 2.

SAFETY OUTCOME 2: CHILDREN ARE SAFELY MAINTAINED IN THEIR HOMES WHENEVER POSSIBLE AND APPROPRIATE

Item 2: Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry Into Foster Care

Navigation Tip: To get to Additional Comments box for item 2 when Item 2 is NA, hit Back button from Item 3 or click on Rating button for Item 2 on navigation tree.

1. Please ensure the purpose of this item is reviewed (i.e. review definitions and instructions). Please ensure reviewers answer each question in the criteria section. This will determine item applicability.
2. Carefully review the item applicability criteria that reviewers selected. For foster care cases, ensure that all foster care entries and all reunifications during the period under review were considered when responding to the criteria.
3. If one criterion is answered Yes then the item is applicable. However, if the caveat that discusses the Safety Plan is answered Yes then the item is not applicable regardless if it meets other criteria.
4. Please take note of the "Definitions" and "Instructions" link on the following page. Definitions provide you with the mindset and information needed in order to accurately rate the item. Instructions provide you with the necessary guidance in order to complete the tool accurately. It is important to review both for each item.

5. Item 2 and Item 3 C + D go together so make sure they match up. If Item 2 is applicable then Item 3 C+D will be applicable also.
6. Remember, the instructions for each supporting question are directly above the actual questions. For example, Question 2A's instructions are immediately above Question 2A.
7. Question 2A is a very focused question. It is asking about safety related services in order to prevent removal or re-entry into out-of-home care. Monitoring of the services, safety planning, assessment of safety will be captured in Item 3.
8. If any of the answers are No, you must complete the box below that particular supporting question.
9. If Question 2A is answered Yes, ask the reviewers to describe which services were provided to the family to ensure they were safety-related. Services offered to the family that were not safety-related should be captured in Item 12B.
10. If Question 2B is answered Yes, ask the reviewers to explain the circumstances that warranted immediate removal.
11. Once you proceed to the next page, the Item 2 rating will appear. This is where reviewers will put the Main Reason in the "Additional Comments" box.

Item 3: Risk and Safety Assessment and Management

All cases are applicable in this item.

5. Questions A & B refer to the environment(s) the child(ren) is in, Question C refers specifically to the adequacy and monitoring of any safety plan identified in Item 2, and Question D refers to safety of the child(ren) before they came into care (if they did).
6. For foster care cases, if the child entered foster care during the period under review but reviewers selected N/A for Item 2, ask the reviewers about the circumstances for removal to determine if any concerns should be noted in Item 3.
7. Do not forget to ensure reviewers answer both parts of A1.
8. If any of the concerns in A1 are checked Yes, and reviewers answered A or B Yes, ask the reviewers to explain their rationale.
9. For foster care cases, the item must answer for both the target child in care and any children remaining in the home.
10. For in-home cases, this item addresses all children in the home.
11. If Question B is rated N/A, ask the reviewers to explain their rationale and ensure that it is consistent with the instructions provided.
12. Discuss the quality of the risk/safety assessments that the agency conducted. Ensure that the frequency and quality of worker visits with the child(ren) and/or parents (in Items 14 and 15) was adequate to appropriately assess risk and safety throughout the PUR.
13. When answering Question 3C, please review the definitions as they provide clear expectations of safety planning.
14. Question 3C – if child was placed immediately during PUR because no safety plan was feasible, the answer should be N/A because there were no safety concerns as the child was placed immediately. Subsequently, D1 and D should be rated N/A.
15. If Question C is answered Yes, ask reviewers to describe the safety plan and how it was monitored.
16. If Questions C and/or D is rated N/A and the question is applicable for assessment, ask the reviewers how they determined that there were no apparent safety concerns during the PUR.

17. Ensure that reviewers are only considering safety concerns when responding to Questions C-F and are not considering risk issues in those questions.
18. Once you past the Item 3 rating, you will then proceed to the Safety Outcome 2 rating, which should be prepopulated for you. This will be the same for each item and outcome rating.

SECTION III: PERMANENCY

PERMANENCY OUTCOME 1: CHILDREN HAVE PERMANENCY AND STABILITY IN THEIR LIVING SITUATIONS

Item 4: Stability of Foster Care Placement

1. Ensure that the reviewers have considered all time periods that the child was in care during the PUR. If you notice that the placement dates do not account for all time periods, ask reviewers if the child was in a placement that is not considered a "placement setting" during those periods.
2. Discuss all the "reasons for change in placement" with reviewers to determine whether Question B is answered appropriately. Ensure that any moves up to higher levels of care because of increased mental health/ behavioral needs have been evaluated carefully. Please review the instructions for Question B as they are quite detailed and provide a lot of guidance to assist reviewers in determining what is or is not a planned change of placement.
3. Reunification in Item 4 – doesn't allow this in table – "N/A this is the current placement" is the correct answer for reunification.
4. If child is on a trial home visit and returns to a different placement, reason for placement should be as if they never went home.[9] (See Footnote)
5. For Question B, if any of the placement changes were unplanned during the PUR, Question B should be answered No regardless of the other placement changes.
6. If any of the boxes other than "None apply, placement is stable" are checked for Question C1, then the answer for Question C should be No.
7. If a child's placement was disrupted during the PUR or is/was not stable, reviewers should assess whether the agency provided any services to the foster parent/caretaker to stabilize or support the placement. This should also be captured in Item 12, Section 12C.
8. NOTE: CAST is referred to as an "institution" in the chart. Since these assessment programs (i.e. CAST) are generally meant to be temporary, 4C1 would be "the child's current setting is in a temporary shelter or other temporary setting" and 4C would be "no" because the most recent placement was not stable as it was a temporary assessment program.

[9] If a child/youth reunifies and the State does not retain custody, or there is not an order specifically stating it is a trial home visit, this ends the foster care episode. A return to foster care, is a new placement episode.

9. For youth who go to a trial home visit [1] (see Footnote) and come back into care before 6 months enter the chart as follows: 1) if they came back into the same placement, document it as 1 placement in the chart – not 2 … then describe what happened in the "additional comments" box. (ex. youth went on a trial home visit on ___ and came back to same placement from this trial home-visit so it's not considered a new placement." 2) if the youth comes back into placement during a trial home visit and enters a new placement setting, do not use the reunification date anywhere. In the chart note the date the initial placement changed as the date the youth came back into the new placement. Note the reason (ex. moved to more restrictive setting).[1] (see Footnote)

Item 5: Permanency Goal for Child

1. If the goals are listed as reunification and reunification the table will not allow you to add the goal twice therefore put reunification in once and in the narrative include the detail. (DO NOT PUT CONCURRENT as it will come up in Question A2 as N/A).
2. Review the table to determine whether Question B is answered accurately. Ensure that reviewers completed the table by noting dates that goals were *established*, not achieved.
3. Discuss the response to Question C and ensure that reviewers considered the child's age, needs, and the circumstances of the case (length of time in foster care, status of caretakers in resolving safety concerns, etc.). In cases in which the appropriateness of the goal is based on a child/youth's "age of consent" for adoption, did reviewers assess the agency's efforts to work with the child around these issues? (e.g., what was the level of work done with the child to determine whether they really do not want to be adopted?)
4. Furthermore, in answering Question C, is it clear that the agency considered all relevant factors when determining the permanency goal? If one of the goals is Other Planned Permanent Living Arrangement (OPPLA), were all other permanency goals considered? If not, the answer to Question C should be No.
5. Ensure that reviewers accurately calculated the child's time in foster care in Question D. Trial Home Visit and Runaway Episodes do NOT count toward the child's time in foster care.
6. If Question E is answered Yes, ask reviewers which Adoption and Safe Families Act (ASFA) TPR criteria the child met.
7. If any exception in Question G1 is checked, discuss the specifics with reviewers to confirm accuracy. Placement information in Item 4 should be reviewed to assess whether the child was placed with relatives at the 15/22 month timeframe. Compelling reasons must be documented in the case file to count as an exception.

Item 6: Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement

1. Ensure that the answer for Question A1 lines up with what the reviewers answered for Question J on the Face Sheet.
2. If concurrent goals were in place, ensure that reviewers responded to Questions B and C appropriately.
3. If Question B is answered Yes but the child has been in foster care for more than the suggested timeframe (12, 18, or 24 months, depending on the goal) and the goal has not yet been achieved, ask reviewers to describe the circumstances to ensure that a delay is justified (see examples in instructions).
4. If Question B is answered Yes and the child has not been in foster care for more than the suggested timeframe but has not yet been discharged from foster care, ask reviewers when the goal is projected to be achieved to ensure that it meets the recommended timeframes in the instructions. Also ask reviewers to describe the concerted efforts that have been made to ensure timely achievement of the goal.

5. Remind QA staff to check with reviewers to ensure that even if the permanency goal was achieved timely, could it have been achieved even earlier? Reviewers need to ensure and explain that the permanency goal was achieved as quickly and safely as possible.
6. Be mindful that the permanency goal achievement questions that are under Question C all pertain to the goal of OPPLA.
7. If Question C is answered Yes but Question C2 is answered "no date," ask reviewers why they believe the child's living arrangement can be considered permanent.
8. After completing Item 6, you are done with Permanency Outcome 1. The outcome rating will be on the following page after Item 6.

PERMANENCY OUTCOME 2: THE CONTINUITY OF FAMILY RELATIONSHIPS AND CONNECTIONS IS PRESERVED FOR CHILDREN

Item 7: Placement With Siblings

1. If the target child does NOT have any siblings in placement DURING the PUR, this item is Not Applicable.
2. Ask reviewers to describe the placement arrangements of siblings placed separately. If Question B is answered Yes, what were the reasons for separate placement? If a valid reason existed, was the separation re-assessed by the agency over time during the PUR?
3. Ensure that only siblings as defined in the instructions are included in the item assessment. Issues related to preserving connections between children who grew up in the same household but are not related biologically or through adoption and/or marriage should be addressed in Item 9.

Item 8: Visiting With Parents and Siblings in Foster Care
NOTE: if siblings are placed in the same home this item will be N/A for sibling visitation

1. Ensure that case participants selected as Mother and Father are accurate based on instructions and case circumstances. You must read the Item 8 Definitions before answering the item. If a parent did not have a relationship with the child before the child was removed, that parent is not considered in this item, even if that is the reunifying parent. This item really focuses on the continuity of the parent/child relationship while the child is in care. A stepparent living in the home is in fact a caregiver and would be reviewed in Items 8 & 11. The same definition is present in item 12B, thus the same interpretation would pertain.
2. Carefully read the applicability questions before answering.
    a. In CPS cases where petitions are filed against 2 separated parents and the youth was living with one but had a relationship with the other and the youth was placed, the youth is considered placed from both homes. If the absent parent has had no relationship with the youth for a significant period of time, the absent parent is not considered as a parent from whom the youth was removed.
    b. In cases where the Division has identified reunification with both parents as a goal – even if reunification more likely with one of the parents – both parents are considered as parents with whom reunification is being pursued.
    c. In cases where adoption was the primary goal throughout the entire PUR, no parents are rated in this item.
3. If visitation frequency for Questions A, B, and E are anything less than "more than once per week", and the question is answered Yes, discuss with reviewers how the frequency was sufficient for the child and whether efforts for more frequent visits were made.

4. Ask reviewers to describe the visitation arrangement (location, length, supervision, etc.) when discussing their responses to Questions C, D, and F.

Item 9: Preserving Connections

1. Ensure the item was not rated on connections the child formed while in foster care. The focus is on maintaining connections the child had at the time they entered care.
2. If, prior to removal, the child had contact and a relationship with biological parents who are not the caregivers the child was removed from or is being returned to, ask whether those relationships should be preserved and were addressed in this item.
3. Do not rate this item based on connections to parents/caregivers from whom the child was removed and/or with whom the child will be reunified, or to siblings who are in foster care. Information about sustaining those connections is captured in other items. However, this item may be rated based on connections with siblings who are not in foster care and other extended family members, such as grandparents, uncles, aunts, or cousins.
4. Connections to caregivers from whom the child was removed may also be included in this item if the goal is not to reunify the child with those caregivers and it is in the child's best interest to preserve those relationships.
5. Ask the reviewers to describe the child's connections and how they were/were not maintained. If the child was not maintained in the same school setting, ask for the reasons and how that decision was made.

Item 10: Relative Placement

1. If Questions B and/or C are answered Yes, ask the reviewers to describe the quality of efforts that were made throughout the PUR and at critical points in the case.
2. If Questions B and/or C are answered N/A, ask about the rationale to ensure it is consistent with the instructions. This is especially important for cases where the child entered placement BEFORE the PUR. The answer could be N/A if it is determined that no further efforts were needed, but if in the reviewers judgment they determined that the agency should have reconsidered relatives who had previously been ruled out and they did not, the answer to Questions B and/or C should be No.

Item 11: Relationship of Child in Care With Parents

1. Ensure that case participants selected as Mother and Father are accurate based on instructions and case circumstances. The same participants should be selected in Items 8 and 11 (see that Item for more detailed criteria).
2. Because the focus of Item 11 is to promote, support, and maintain the child's relationships with the parents/caregivers from whom the child was removed, do not include in this item a parent who did not have a relationship with the child prior to the child's entry into foster care, even if the goal is to reunify with that parent. Services to support a parent in developing a new relationship with a child may be assessed as a service need in Item 12 (see Item 12 instructions).
3. Support the foster parents provide to the birth parents can be considered in this item.
4. Do not rate this item based on the visitation between the child and parent, which is captured earlier in Item 8.

SECTION IV: CHILD AND FAMILY WELL-BEING

WELL-BEING OUTCOME 1: FAMILIES HAVE ENHANCED CAPACITY TO PROVIDE FOR THEIR CHILDREN'S NEEDS

Sub-Item 12A: Needs and Services of Child

1. Ask reviewers to explain what the child(ren)'s needs were during the PUR. Were all of these needs accurately assessed by the agency? Consider the circumstances of the case, age(s) of the child(ren) etc. as you discuss needs. Also ask about how needs were assessed. Did the worker visit with the child(ren) frequently enough to allow for ongoing assessment? Did the worker ask about the child(ren)'s needs with the child(ren)'s caretakers and/or foster parents? Ensure that reviewers answered Question A1 based on the adequacy of the assessment(s).
2. **REMEMBER**: It is very rare that children involved with DCYF **do not** have a need. From a QA perspective it is easy for reviewers to revert to the only needs the child has are related to education, medical and behavioral. Coping skills, interpersonal relationships, etc. would go in Item 12A.
3. Ask the reviewers to describe the services that the child(ren) received during the PUR. Discuss whether the services addressed all of the child(ren)'s needs.
4. Ensure that assessment and services related to education, physical health, and mental health were not considered for this item.
5. Needs that should be assessed in this item include those related to social/emotional development that are not connected to other physical health or mental health issues. These may include social competencies, attachment and caregiver relationships, social relationships and connections, social skills, self-esteem, and coping skills.
6. For foster care cases, if the target child is an adolescent, ensure that independent living services were addressed.
7. Focus on the agency's provision of services during the period under review. If services were provided before the period under review, and an assessment conducted during the period under review indicated no further service needs, then the answer to Question A2 should be Not Applicable.
8. Determine whether the services provided matched identified needs. For example, were the services provided simply because those were the services available or were they provided because the assessment revealed a particular need for a particular type of service?
9. Item 2 should address all the safety-related services provided to the family. Do not capture those services in this item.

Sub-Item 12B: Needs and Services of Parents

1. Ensure that the right case participants were selected as "Mother" and "Father" based on instructions and case circumstances. Ensure that the same participants were rated in Items 12B, 13, and 15.
2. For In-Home services cases, "Mother" and "Father" in Items 12, 13, and 15, are typically defined as the parents/caregivers with whom the children were living when the agency became involved with the family and with whom the children will remain (for example, biological parents, relatives, guardians, adoptive parents). A stepparent living in the home is in fact a caregiver and would be reviewed in Items 12B, 13 and 15.
3. If a biological parent does not fall into any of the categories above, determine whether that parent should be included in this item based on the circumstances of the case. Some things to consider in this determination are: the reason for the agency's involvement and the identified perpetrators in the case, the status of the children's relationship with the parent and the length of case opening. If a biological parent indicates a desire during the period under review to be involved with the child and it is in the child's best interests to do so, they should be assessed in this item.
4. For Foster Care (FC) cases, "Mother" and "Father" in Items 12, 13, and 15 are typically defined as the parents/caregivers from whom the child was removed and with whom the agency is working toward reunification. For FC cases, "Mother" and "Father" in Items 12, 13, and 15 include biological parents who were

not the parents from whom the child was removed. Additionally, "Mother and "Father" include adoptive parents if the adoption has been finalized during the period under review.

5. Because multiple case participants can be assessed in these questions, consider applicability for all appropriate case participants before determining that the rating should be Not Applicable.
6. If the whereabouts of a parent were unknown during the PUR and the agency did **not** make concerted efforts to locate them, the applicable item questions for that parent should be answered No, resulting in an Area Needing Improvement rating for Sub-Item 12B as well as Item 12. This parent should **not** be assessed in Items 13 and 15. Questions for that parent in those items should be answered N/A. In Well-Being Outcome 1, concerns about efforts to locate a parent should only be reflected in Item 12.
7. Ask reviewers to explain what the mother's and father's needs were during the PUR. Were all of these needs accurately assessed by the agency? Consider the circumstances of the case, reason for the agency's involvement, length of time case has been open, case plan progress, etc. as you discuss the parents' needs. Also ask about how needs were assessed: did the worker visit with the parent frequently enough to allow for ongoing assessment? Ensure that reviewers answered Question B1 based on the adequacy of the assessment(s).
8. If the reviewers feel the agency made concerted efforts to assess mother/father's needs to provide appropriate care and supervision and to ensure the well-being of the children, then they could answer Yes to 12B. If a parent is resistant, concerted efforts should involve both trying to engage them as well as trying to learn about their needs from other available and relevant resources. Reviewers could answer NA to the needs, if they were unable to determine needs based on the concerted efforts described above.
9. Circumstances must be considered when determining whether to include an uninvolved parent in the assessment of this item for in-home cases. For example, reason for agency involvement, the identified perpetrator, the child's relationship with the uninvolved parent, if the case was only opened for a short time and the concerns with the family were not significant (no ongoing safety issues or high risk concerns), it may not be necessary for the agency to contact an uninvolved parent since the agency's involvement is very limited. For cases that are court-involved and not voluntary, for cases opened for a longer period of time due to ongoing safety concerns, or for cases in which the custodial parent is not successfully addressing the concerns, and there is a risk of foster placement, the agency should make efforts to contact and inform uninvolved parents about the status of the children and engage them in meeting the needs of the children.
10. Ensure that paramours have been appropriately assessed in this item, as applicable. Paramours typically should not be included in the definition of "mother" or "father" but instead should be considered through their relationship with the primary caregiver(s) who will be caring for the children. For example, if the biological mother is the caregiver that the child(ren) will be reunified with and her boyfriend needs services to ensure he is safe with the child(ren) because he has a lot of access to them, the agency should assess and work with him, but that would be captured under "mother" in Item 12 because it affects the assessment of her protective capacity. If he doesn't comply with services, that could necessitate a change in assessment and service provision to the mother.
11. For foster care cases, if biological parents did not have an established relationship with the child prior to removal, the agency should assess whether developing a relationship with biological parents would be in the child's best interests and determine whether anything should be done to support that goal. Services in support of such needs (e.g., providing for visits, phone contact, arranging for therapy) should also be captured in this item.
12. Ask the reviewers to describe the services that the mother and the father received during the PUR. Discuss whether and how these services addressed all of their needs and whether the services enhanced the parents' ability to provide appropriate care/supervision of their child(ren) and ensure their safety and well-being. Were

there any barriers to accessing services? Were services matched to the parent's needs? Were they culturally appropriate?

Sub-Item 12C: Needs and Services of Foster Parents

1. If there are multiple foster parents during the PUR, ensure that reviewers included all of them in the assessment of the item.
2. In some cases, foster parents may be a potential permanent placement for the child and if so their needs related to permanency achievement should also be assessed in this item.
3. Ask reviewers to describe how the foster parents' needs were assessed. Were there any concerns about their ability to care for the child that were not assessed and addressed? (Refer to Item 4 to assess the child's stability in the placement).
4. Ask reviewers to describe any services that the foster parents received during the PUR. Did services meet the identified needs?

NOTE: Reviewers **DO NOT** need to put anything in the final Item 12 box! All the information is already in 12A, 12B, and 12C.

Item 13: Child and Family Involvement in Case Planning

1. Reviewers should use the same definitions for mother and father as they used in completing Item 12.
2. If reviewers answered Yes to A, B, or C, ask them to describe how the agency actively involved each person in case planning. "Actively involved" means that the agency involved the mother or father in (1) identifying strengths and needs, (2) identifying services and service providers, (3) establishing goals in case plans, (4) evaluating progress toward goals, and (5) discussing the case plan.
3. If the case is a foster care case, answer No to this question if there is no case plan in the case file.
4. Do not assume that a child's knowledge about their case plan is an indicator of active involvement.

Item 14: Caseworker Visits With Child

1. Determine the most typical pattern of visitation during the PUR because the actual frequency may vary in specific time periods.
2. If visitation frequency is less than once per month, Question A should be answered No unless reviewers have substantial justification for answering Yes.
3. Discuss with reviewers how visitation frequency met the needs of the child in ensuring safety, permanency, and well-being.
4. Base your determination on the frequency necessary to ensure the child's safety, permanency, and well-being and not on compliance with state policy requirements regarding caseworker contacts or visits with the child. For example, if state policy is that the caseworker should visit the child at least once a month and they complied with that, but you determine that given the circumstances of the case (for example, there are safety concerns), the caseworker should visit more frequently, then the answer to Question A should be No.
5. If the child is in a placement in another state, you should determine whether a caseworker from the jurisdiction in which the child is placed, or a caseworker from the jurisdiction from which the child was placed, visits with the child in the placement on a schedule that is consistent with the child's needs.
6. For an In-Home Services case, any children in the home who were assessed in Item 12 should be visited at least monthly unless there is substantial justification for less than monthly visits. Frequency of visitation with other children in the family home should be determined based on the circumstances of the case, such as any risk and

safety concerns present during the period under review, the age and vulnerability of the children, the reason for the agency's involvement with the family, etc.

7. If Question B is answered Yes, ask reviewers to describe the quality of the visits (location, length, etc.). Ensure that the child(ren) was/were visited alone for at least part of each visit and that conversations focused on the child(ren)'s needs, services, and case goals.
8. For FC cases, if the child is non-verbal, ensure that reviewers visited the child in the foster home, assessed the child's living arrangements, and assessed the child's interactions with caregivers when determining the quality of visitation.

Item 15: Caseworker Visits With Parents

1. Reviewers should use the same definitions for mother and father as they used in completing Item 12.
2. If visit frequency is less than once per month, Questions A1 and B1 should be answered No unless reviewers have substantial justification for answering Yes.
3. Discuss with reviewers how substantial justification should include worker efforts to set up visits, reason why the parent was non-responsive, and whether the frequency that did occur was enough to address the child's safety, permanency, and well-being.
4. If Question C and/or D is Yes, ask reviewers to describe the quality of the visits (location, length, content, etc.)
5. Please use a similar lens to the one used in rating Item 14 to determine the necessary frequency and the overall quality of the caseworker visits with the parents.

WELL-BEING OUTCOME 2: CHILDREN RECEIVE APPROPRIATE SERVICES TO MEET THEIR EDUCATIONAL NEEDS

Items 16: Educational Needs of the Child

1. Foster care cases are Not Applicable if the child is age 2 or younger and there are no apparent developmental delays.
2. If a child is 2 years old or younger and has been identified as having developmental delays, the case may be applicable if the developmental delays need to be addressed through an educational approach rather than through physical therapy or some form of physical health approach. In these latter cases, the issue of developmental delays would be addressed under Item 17.
3. In-home services cases are Not Applicable for an assessment of this item if the reviewer determines that, during the period under review, there is no reason to expect that the agency would address educational issues for any children in the family, given the reason for agency involvement or the circumstances of the case. This "non-applicability" applies even if there is evidence in the case file that the agency has learned that the parent/caregiver has obtained educational services for the children.
4. If the case is a foster care case, Question A should be answered only for the child in foster care, even if the child was reunified during the period under review and there are other children in the home.
5. If the case is an in-home services case, Question A should be answered for all children in the home who meet the case applicability requirements.
6. If there were "services needed but not provided" in the table but Question B is answered Yes, discuss what concerted efforts were made to advocate for services.

WELL-BEING OUTCOME 3: CHILDREN RECEIVE ADEQUATE SERVICES TO MEET THEIR PHYSICAL AND MENTAL HEALTH NEEDS

Item 17: Physical Health of the Child

1. All foster care cases are applicable for an assessment of this item.
2. For in-home services cases, A1 and A2 should be answered for all children in the home who meet the case applicability requirements. A1 or A2 may be Not Applicable if only one of the issues (physical or dental health) was relevant for assessment in an in-home services case. If question A2 is Not Applicable, then question B3 also should be Not Applicable.
3. If there were "services needed but not provided" in the table but Question B is answered Yes, discuss the circumstances with reviewers to ensure item instructions were followed.
4. If question B1 is answered Yes or No, discuss with reviewers which medication was prescribed and how it was monitored. Determine if the agency provided "appropriate oversight," which includes 1) ensuring regular monitoring by a physician, 2) regularly discussing appropriate administration and child's experience with the medication, and 3) if the state policy for medication monitoring was followed. Policy 1653 can be found in QA binder in the policy section. The narrative should describe what the agency did to ensure that medications were being administered appropriately, rather than what the foster parent or residential provider did.
5. For placement cases - NH has a state mandate in place that protects reproductive health information for minors age 14 and over. While there is an expectation that staff will monitor any medication a child/youth is prescribed there should be no documentation made in the case practice review materials of medication related to reproductive health.

Item 18: Mental/Behavioral Health of the Child

1. Foster care cases are applicable for an assessment of this item if the reviewer determines that, during the period under review, the child had existing mental/behavioral health needs, including substance abuse issues. If the child had mental/behavioral health issues before the period under review that were adequately addressed and there are no remaining needs during the period under review, the case should be rated as Not Applicable.
2. In-home services cases are Not Applicable for an assessment of this item if the reviewer determines that there is no reason to expect that, during the period under review, the agency would address mental/behavioral health issues for any children in the family, given the reason for agency involvement or the circumstances of the case. This "non-applicability" applies even if there is evidence in the case file that the agency has learned that the parent is effective in taking care of the children's mental/behavioral health needs.
3. "Behavioral health needs" includes needs related to behavioral problems that are not always specified as mental health needs, including substance abuse.
4. If there were "services needed but not provided" in the table but Question B is answered Yes, discuss the circumstances with reviewers to ensure item instructions were followed.
6. If question B1 is answered Yes or No, discuss with reviewers which medication was prescribed and how it was monitored. Determine if the agency provided "appropriate oversight," which includes 1) ensuring regular monitoring by a physician, 2) regularly discussing appropriate administration and child's experience with the medication, and 3) if the state policy for medication monitoring was followed. Policy 1653 can be found in QA binder in the policy section. The narrative should describe what the agency did to ensure that medications were being administered appropriately, rather than what the foster parent or residential provider did.
5. Oversight of prescription medications guidance:

a. Multiple prescription medications can cause undesirable side effects. Because of the side effects, some children will not take the medication as prescribed.
b. Staff should know how the child is reacting to the medication. Whether the child is having side effects as a result of the medication. They should also know if the physician is aware of any other medications the child is on and what reactions those meds might have with the prescribed medication from that physician.
c. In terms of frequency of monitoring, please consider the type of medication, the other medications and changes in those medications, and how closely the administering of the medication is monitored.
d. Beginning and ending certain medications are critical times for medication review.

Submission for QA process:

When reviewers are completely finished item 18 and **everything is complete:**

- **Hit submit** which takes you to case overview sheet-- you can also get to case overview sheet on the left side of the page
- **Submit to QA** then shows as an option on the top right.
- Click on it (and it asks if you want to submit for QA) **hit ok**,
- You will then be asked to **confirm that no proper names** are included in narrative fields-there is a report you run to check this. It will show you items with proper names in them that you have to fix.
- If you need to remove proper names, go back into the tool and fix them
- Then hit **submit for QA button again**-and it will tell you if submission succeeded.
- If tool is not completed it will tell you.
- Keep submitting to QA in the same manner after you have responded to the QA comment-always mark **DONE** so QA can track that comments are resolved.

A texting system is in place for notification to and from your assigned QA staff. Alert them that you have completed your responses and it is ready for a recheck.
When QA1 recheck is complete, QA 1 person hits Submit as Complete on Case Overview. When QA 2 rechecks are complete, QA 2 person selects “Finalize Case” on Case Overview.